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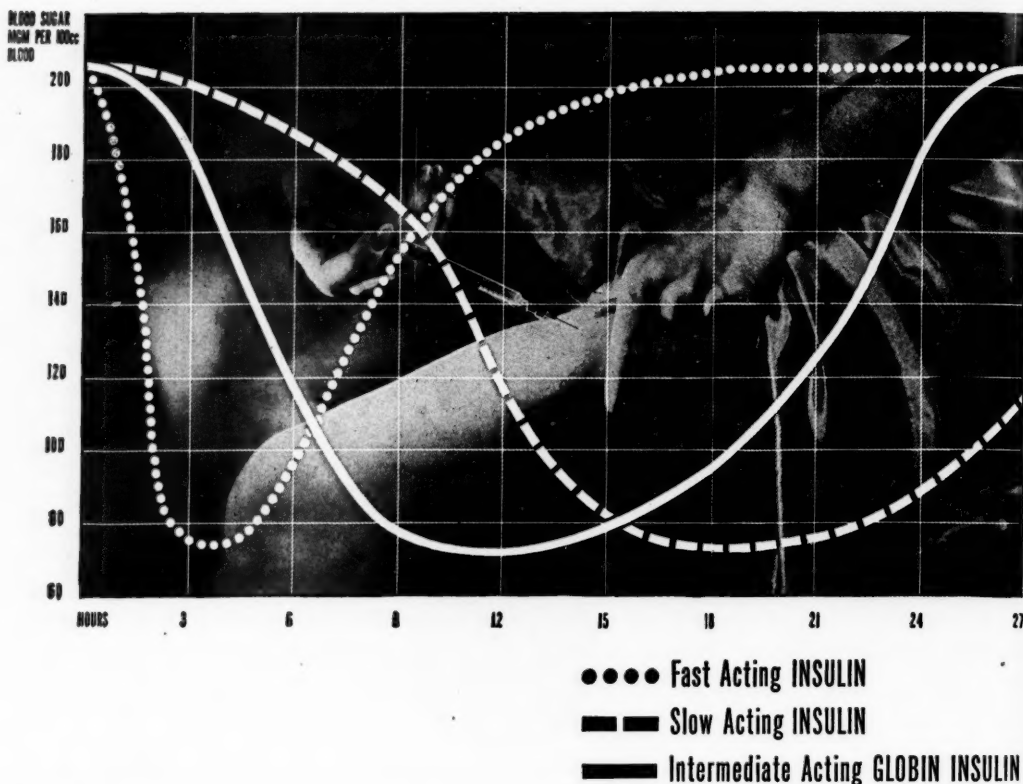
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**THE RHODE ISLAND MEDICAL SOCIETY
THE RHODE ISLAND DENTAL SOCIETY
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Today, there are 3 types of insulin...

THE PHYSICIAN now has a new intermediate-acting type of insulin with which to treat his diabetic patients—'Wellcome' Globin Insulin with Zinc. Originally there was only quick-acting, short-lived insulin. Then came a slow-acting, long-lived form. And now with Globin Insulin he has a moderately rapid-acting agent which persists for sixteen hours or more, enough to cover the period of maximum carbohydrate intake. This activity is sufficiently diminished by night to minimize nocturnal reactions. Physicians will do well to consider the advantages of this new third insulin for their diabetic patients.

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No. 9

NEWER DEVELOPMENTS IN THE ETIOLOGY AND TREATMENT OF DIABETES*

ELLIOTT P. JOSLIN, M.D.

The Author. *Elliott P. Joslin, M.D., of Boston, Mass. Medical Director, George F. Baker Clinic, New England Deaconess Hospital.*

I HAVE never ceased to be grateful to the physicians of Rhode Island, because in 1940 your replies to my questionnaire clinched my argument that diabetes is a universal disease. In preparation for the Billings Lecture before the American Medical Association, I had just completed a survey of diabetes in Arizona with the help of its own State Medical Society and showed that the morbidity of diabetes in Arizona was comparable to that in Rhode Island and other eastern states, despite the fact that the mortality rate there was 10 per 100,000 and 40 per 100,000 in Rhode Island. I had been able to prove that diabetes was common among Arizona Indians, most frequent in the leisurely, less frequent in the nomadic tribes, and that in the hospitals and jails it was comparable to that in the East, but the final argument rested upon a survey of diabetes among the doctors in Arizona compared with those in Rhode Island. The results demonstrated that morbidity rates were similar. One doctor in 42 in Arizona had diabetes and one doctor in 36 in Rhode Island. Mortality rates are higher in the East because we have more females, more Jews, an older population, closer medical supervision and a better opportunity for the gathering of medical statistics. Eventually the mortality of diabetes throughout the whole United States will resemble that of the mortality of diabetes in Rhode Island.

The importance of the rank which diabetes will hold as a cause of death in the future is, however, little appreciated. In 1900 it was 27th as a cause of death and now it is 9th. With the increasing conquest of infectious diseases, including tuberculosis, the reduction of infantile deaths and accidents, it will become 5th and if we group deaths

from heart disease, apoplexy and Bright's disease under the basis of arteriosclerosis, it will stand 3rd, with arteriosclerosis and cancer only exceeding it.

The discovery of insulin was wonderful, because it allowed children to live, it prolonged the duration of life of diabetics three-fold, it allowed them to work with vigor and courage and support themselves. All these marvels insulin has wrought and is now accomplishing, but I would point out that its usefulness is only in its beginning and that it will be of still more value in the future, because then its task will be to protect the lives and happiness of all those individuals who are living, but because of increasing age are more liable to diabetes and destined to come down with it. Lives saved by the conquest of disease in young people are lives exposed to diabetes when they reach middle or old age. For the protection of these, at present insulin is the mainstay. As time rolls on Banting's discovery will achieve more and more recognition.

To meet the diabetic demands of the future, we must provide and you can imagine what an encouraging sign it was to me to learn through Mr. Harris H. Bucklin, Chairman of the Rhode Island Hospital Building Fund, and your Dr. Alexander Burgess that this is exactly what Providence is doing in its new hospital program. Dr. Burgess was kind enough to prepare for me a note upon the present and future endeavors of the Rhode Island Hospital and it is such a model for other communities that I am incorporating it verbatim into my remarks. Dr. Burgess writes, "The Department of Medicine has always been interested in the work with diabetic patients. The Out-Patient clinic is one of the few special clinics that has been maintained during the war. As far as I know, it is the second oldest hospital Out-Patient Clinic for diabetes in New England, the first having been established by Dr. F. Gorham Brigham of the Massachusetts General in 1915, and the clinic in this hospital having been established in 1916.

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*Presented at the 134th Annual Meeting of the Rhode Island Medical Society, at Providence, on May 17, 1945.

"Recently a special interest has been aroused in the treatment of severe diabetic ketosis and coma, and a special group of consultants has been formed to be called in by the Service in case of patients in coma. The details of emergency treatment have been worked out in connection with the Department of Biochemistry, headed by Dr. Bowman.

"The Medical Department believes that the treatment of diabetes in the hospital should be a unified affair, with treatment of the patient both in the Out-Patient clinic and in the House a continuous whole. The new Out-Patient Department in the new hospital will, we believe, greatly facilitate this unity of treatment and study. It is our ideal that certain of the visiting staff should become particularly proficient in dealing with diabetes, while at the same time through their efforts the entire staff is broadly educated in the care of the disease.

"In view of the fact that education of the patient and social studies of the patient form such a fundamental part of his treatment, we believe that further careful planning to provide a good opportunity for patient-education and for improved cooperation with our Social Service Department, who have always been the backbone of our clinic, should be established."

In a personal letter from Mr. Harris H. Bucklin, Chairman of the Rhode Island Hospital Building Fund, he adds, "The Diabetes Clinic, referred to by Dr. Burgess, will be established in the new hospital at an expenditure of \$54,000."

In Boston, too, we are exerting ourselves for diabetes and hope to have fifty new beds for the disease at the New England Deaconess Hospital in the near future. Special provisions will be made for a diabetic coma unit, the study of complications in the young, for diabetic pregnancy cases and for the expansion of laboratory facilities for research. I confess that I am proud to be able to say that already over 2,200 of our patients have contributed to make these plans a reality. Neither Providence nor Boston should stop with bricks and mortar. Endowment funds should be created not only for clinical care of patients, but for research. Moreover, each hospital in Rhode Island and in Massachusetts, no matter how small, could and should improve its methods of diabetic treatment. They should afford better protection to the diabetics in their immediate vicinity. And from what I have seen with my own eyes from my own patients, I know that the diabetics living near the hospital will be only too ready to give sufficient money for better and cheaper laboratory facilities, facilities which will be open day and night, holidays and Sundays for diabetic emergencies. Also better provision must be made for nurses and other personnel and for the teaching of the individual case.

Each one of the 800,000 and more diabetics in the country should look upon his neighborhood hospital as his haven of refuge. Diabetics stand ready to give money to save human lives from diabetic coma and other diabetic complications in emergency hours as well as upon other occasions. All the hospitals need to do is to ask diabetics and their relatives—and remember one individual in four in the United States has a diabetic relative—to furnish the cost for better treatment.

Alloxan. Alloxan injected into an animal will produce diabetes within twenty-four hours. I have not yet met an individual who had even conceived that a chemical would be discovered which could produce diabetes. The literature upon alloxan has been summarized by me in two progress reports in New England Journal of Medicine and to those I will refer for details^{1, 2}. It is a chemical with selective and specific action. Injected into a rabbit it selects for destruction the beta cells of the islands of Langerhans of the pancreas and is so specific in its action that it causes little or no injury to the rest of the body. In my mind's eye I visualize it as a bomb dropped from an aeroplane sailing over 14,000 blocks in Berlin which, when released, invariably hits the same target in the same block no matter how many times the pilot or other bombers return to the attack. It acts quickly within five minutes after injection, and destroys the islands, but in small doses it can simulate the slow onset of diabetes. The drug can be neutralized with alkali or blood but not with insulin. After injection it can be demonstrated up to five minutes in the circulation and also in the islands of Langerhans but not after that time. It produces the symptoms and signs of diabetes in the animals concerned. Polyuria, hyperglycemia, hyperlipemia, acidosis, coma and cataracts can be demonstrated. A recovery of a mild case of diabetes caused by alloxan has been reported. Alloxantin, a derivative of alloxan, will act similarly and another preparation, xanthopterin, is probably akin to it. These various products are in the uric acid group and alloxan can be made out of uric acid, so that one cannot help thinking, perhaps wishfully, that this drug may play an important factor in human diabetes. It is not inconceivable that at some time, somehow, in some way, its formation or neutralization can be overcome or some product be found which might render immune to diabetes the relatives of diabetics. Last year experiments with alloxan were carried out in eight different countries of the world. The prospect is bright for a new understanding, even if not now for a new treatment of the diabetic complex.

¹Joslin, E. P., Diabetes Mellitus, New Eng. Jour. Med., 230:425-431 (Apr. 6) 1944.

²Joslin, E. P., Diabetes Mellitus, New Eng. Jour. Med., 232:219 (Feb. 22) 1945.

Treatment. New plans for the management of diabetic cases are going forward despite the lack of hospital beds. At present it is only the severe patient who can gain admission to a hospital. Recently in our own group 75 per cent of the cases in the hospital had complications requiring consultations with specialists on the staff. Most of these cases were bed patients and instead of gathering them together in the classroom only one in five, or even one in ten, is well enough to attend the diabetic instruction classes. To make up for lack of beds we have found that ambulatory cases could receive intensive education in the course of a week in a diabetic nursing home. The eagerness of patients to learn all possible in a few days allows a quick turnover of cases for instruction and is gratifying. Any doctor who is interested in treating many diabetics and cannot get his patients into a hospital certainly should try to utilize the services of a nursing home or the home of another diabetic. The third group of patients must be treated in the office, but for these working diabetics busy doctors do not have time to give the patients what they need. Line upon line and precept upon precept is what these individuals require. It is true that they must make fairly frequent visits for the first one or two weeks of introductory treatment, but even then the doctor simply cannot do justice to them. By no means will it be necessary that he have a nurse to supplement training, although such is desirable. He can educate a nurse's aide or a technician to do much of this work. In this way expense to the patient can be reduced to a minimum. If the patient really wishes to learn he can do so at little cost. I hope very soon we can set up at the New England Deaconess Hospital short courses for teaching diabetics, so that physicians can send to us nurses, technicians, or secretaries for instruction.

Diet. By general agreement the carbohydrate in the diet of the diabetic today is as seldom under 150 grams as it is over 200 grams. Protein is prescribed chiefly according to the age and weight of the patient to allow for growth and fat is determined almost exclusively by regulation of the body weight. Success with diet often depends upon spreading the meals out over the entire waking hours of the day—an early breakfast, late evening dinner with a light lunch in the forenoon, afternoon and on retiring. By these means one avoids a great deal of food at one time and thus favors a better utilization of it and, second, counteracts any tendency to insulin reactions between meals. I find that more calories are essential for the diabetic patient today than formerly because with insulin his health is so much better that he is more active.

Exercise. Exercise is just as important now as formerly. It works so well that it often leads to an insulin reaction unless one secures extra food.

When we were using regular or crystalline insulin alone we often waited until the first symptoms of a reaction appeared before attempting to counteract it with carbohydrate, but with the use of protamine zinc insulin one must be more forehanded and give a little extra carbohydrate, and often protein and fat, at the beginning or just before the unusual exercise is to begin. No better proof of the value of exercise to the diabetic could be asked than the fact that he will develop a low blood sugar and an insulin reaction unless he allows for it.

Exercise on the other hand is a two-edged sword. It lowers the blood sugar if the patient is a mild diabetic and is producing enough of his own insulin to utilize the calories he is consuming and it does the same for a severe diabetic who is supplementing his own lack of insulin with injections of insulin. But danger lurks when a severe diabetic or a diabetic whose disease is uncontrolled attempts marked exercise. Then he is liable to go into diabetic coma, because for the energy expended, based chiefly upon calories derived from fat, acidosis will appear. The diabetic always must have insulin, either his own or that which he can secure from another animal.

Insulin. Protamine zinc insulin will control the diabetes of an overwhelming percentage of elderly patients. Conversely children require both "quick-acting" and "slow-acting" insulin, because they must not only survive but grow and during the day-time for their exercise take an additional supply of food. In our experience in treating children, adolescents and adults through middle age, we have had better results and have seen better results giving the crystalline and protamine zinc insulin separately than by using a mixture of the same. We have separated the insulins for fear patients will get confused. Presumably within one or more years a new type of insulin combining the advantages of crystalline and protamine zinc insulin will come on the market which will have such wide approval that it will be less dangerous for patients than a variety of special insulins which might give reactions at unusual hours.

It is certainly gratifying and instructive that the diabetics have learned how to use insulin as well as they have, but it is a fact which we must not ignore that often they do not understand how to measure U-40 and U-80 insulin or comprehend the method of administering it with a new syringe if their old syringe is broken. Anything which will simplify the administration of insulin spells safety for the diabetic.

Diabetic coma. The importance of prompt treatment of diabetic coma has been shown by my colleague, Dr. Howard F. Root.³ He found from a

³Root, H. F., The Use of Insulin and the Abuse of Glucose in the Treatment of Diabetic Coma: J.A.M.A., 127:557 (Mar. 10) 1945.

A CRITIQUE OF PSYCHOSOMATIC MEDICINE*

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AT ALMOST any medical gathering where the words psychosomatic medicine are mentioned one is apt to hear two contrary, divergent and opposing points of view. The one attitude is characterized by such expressions as, "What is all this new fangled nonsense?" The other with equal conviction declares psychosomatic medicine to be "old stuff." "Why, I've practised it all my life!" is the customary comment.

Now the layman has a simpler, more naive, more trusting attitude. Eager to grasp at any straw of salvation he turns to this new magic with optimism and the expectation of great things. He takes his bleeding ulcer to the nearest available psychiatrist and thinks that by spilling his inmost secrets into receptive ears he will emerge not only in a state of grace, but with his duodenal cap restored to its normal contours.

The articles on psychosomatic medicine which have recently appeared in some of our popular weeklies have seduced him into his new-found faith. He refers airily to "psychomatic medicine."

The truth is, I believe, that the concepts we are dealing with in this field are both old and new. During the period of rapid technological expansion of medicine the classical attitude of considering the patient as a whole was abandoned and forgotten. This attitude is that which is old in our concept. What is new in it has been treated, as are most new ideas, first with denial and ridicule, then with fairly general acceptance.

Let me expand these assertions a bit further. From antiquity the notion that the mind and body are interdependent functions has ever and again recurred. In another place¹ I have quoted from the writings of Plato—more than two thousand years ago—to wit: "... so neither ought you to attempt to cure the body without the soul; and this is the reason why the cure of many diseases is unknown to the physicians of Hellas, because they are ignorant of the whole, which ought to be studied

also; for the part can never be well unless the whole is well. . . . For this is the great error of our day in the treatment of the human body, that physicians separate the soul from the body".

Skipping lightly over the intervening centuries we encounter that familiar medical sage and rebel Paracelsus—a contemporary of Christopher Columbus—who declared: "He who wants to know man must look upon him as a whole and not as a patched-up piece of work." In our own epoch there have been wise and great physicians who have not lost themselves in the forest because of their preoccupation with the trees. Speaking of a woman probably suffering from low back pain, Sir Clifford Allbutt² said: "However bitter and repeated may be her visceral neuralgias, she is told either that she is hysterical or that it is all uterus. In the first place she is comparatively fortunate, for she is only slighted; in the second case she is entangled in the net of the gynecologist who finds her uterus, like her nose, is a little on one side, or again, like that organ, is running a little, or it is flabby as her biceps, so that the unhappy viscus is impaled upon a stem, or perched upon a prop, or is painted with carbolic acid every week in the year, except during the long vacation when the gynecologist is grouse-shooting or salmon-catching. . . ."

This tendency to explain symptoms on the basis of some incidental pathological finding dominated medical thinking for a good 50 years and was the natural outcome of the training in the autopsy room which our predecessors enjoyed.

With the shift in emphasis toward function instead of form—with the emphasis on physiological and chemical discoveries—a counter tendency became manifest. This resulted again, however, in the neglect of the individual in favor of the workings of his parts. Had it not been so, medical science could not have made such strides in its seven league boots.

In psychosomatic medicine we are observing another tendency at work. True, we do try to take the whole patient into account, but we now tend to explain perhaps too many symptoms on the basis of some neurotic disorder. Such disorders are ubiquitous. They are the common lot of the common man. Their presence need not necessarily be related to the illness or disease under investiga-

*Presented at the 134th Annual Meeting of the Rhode Island Medical Society, at Providence, May 16, 1945.

tion. But, on the other hand, they may well be. This is the meaning and purpose of psychosomatic medicine: to discover in each patient how much of his disturbance is related to a disturbance of his emotions and what, if anything, can be done about it.

Here we will need to depend upon new concepts and new knowledge. For the beginnings of these concepts we must turn back a century to the Germany of the early eighteen hundreds. In our time and place it is Dr. George Draper³ who deserves credit for his emphasis on the psychological panel of human constitution. As early as 1928 he published a paper in the *Journal of the American Medical Association* with the title: "Disease: A Psychosomatic Reaction." Later the more euphonious *cho* was inserted. There are those who cavil at the word. I do not like it myself. Nature does not recognize such constructions. There is no psyche without soma and there is no soma without psyche. The mind and body are a unity. For convenience we must divide them because we need different tools for studying them. We cannot scrutinize the emotions with a microscope nor measure the blood flow through the kidneys by holding a sympathetic interview with them. But the purpose of the dichotomy is ultimate fusion—the understanding of the whole organism. For psychosomatic medicine in the end will turn out to be nothing but good medicine—even if during the period of propaganda and sales pressure it may, at times, blunder and bluster.

You will have guessed, therefore, that I look upon psychosomatic medicine not as a specialty but as a point of view in diagnosis and treatment and as a springboard for research. As such it derives its factual and theoretical bases from our knowledge of the anatomy and physiology of the autonomic and sympathetic nervous systems, from the discoveries of the endocrine apparatus—more especially from the classical studies of Cannon on the emergency function of the adrenal glands and his description of bodily changes in pain, hunger, fear and rage. Pavlov's work on conditioned reflexes and on the habits of such organs as the stomach and the salivary gland, which can be trained to highly specific stimuli, has contributed much to our understanding. But more than any of these the discipline which above all others has given us insight into the dynamics of human emotions is psychoanalysis. It is concerned with the passions, feelings, relationships, behavior and motives of men and women; its daily task is to study and to understand the working of the emotions. When the hidden and forbidden zone of man's erotic life was still too dangerous to investigate, it braved this frontier, but in common with psychiatry it has now extended its terrain to include man's inner life and outward behavior. No one has a better opportunity

than the psychoanalyst to observe the role of emotions in health and illness. When again and again he sees common colds, sinusitis, respiratory infections, skin eruptions, headache, digestive upsets, constipation, diarrhea, palpitation, precordial distress, dyspnoea, appearing in the setting of emotional conflict, he would be a dullard indeed if he did not suspect a close connection between the things he witnesses. That his observations are sometimes casuistic and empirical and unsupported by statistical data he will not deny, but it is worth remembering that science has its beginnings in just such crude observations which later may be refined, critically appraised and controlled, and even used as the basis for experiment.

When such insights as are gained by psychiatric and psychoanalytic investigations are combined with an understanding of physiological processes, of the pathways through which emotions can be discharged and the organs in which they are expressed, then we are in possession of the kind of knowledge we need for the study of psychosomatic problems. Neither kind is sufficient without the illumination of the other.

If, for example, we were going to inquire into a relatively simple bodily process such as the shedding of tears, it is evident that no study of the electrolyte concentration of the tears themselves, or of the morphological structure of the lachrymal glands, or of the action currents in the facial nerve, even if measured with a cathode ray oscillograph, could give us any information about the mood of the person who was crying. To get such information we should need quite different methods.

We might discover in one individual that weeping was a highly conditioned response to a certain set of circumstances; that because of specific events in his past life, a stimulus which would be of no moment for one person opened the flood gates for another. Or, again, that in one, tears were the expression of sadness, in another of anger, in a third of joy, in a fourth of pain. If it were to our interest to stop the flow of tears or to prevent them, we could, of course, administer large doses of atropine, cut the appropriate branches of the facial nerves or extirpate the lachrymal glands, or we could, by a long process of deconditioning and reeducation render the person less reactive to a particular stimulus.

Now this analogy can be carried over without much elaboration into the field of clinical medicine. Wherever the tonus of smooth muscle is involved, or the calibre of a hollow viscus, or the secretion of glands or the vascularity of an organ we are face to face with a set of conditions in which emotional tension may play a determining role in producing impaired function.

A case in point is peptic ulcer. The psychological study of the lives of patients suffering from ulcer

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has brought important facts about them to light. Apparently they are burdened by certain characteristic conflicts which they are unable to resolve. What appears outwardly to be a hard-driving, active, efficient go-getter proves actually to be a hungry, dependent man whose unsatisfied cravings for love he is unable to accept because they are too humiliating to him. They do not correspond to the picture he has of himself. He tries hard to compensate for his essential weakness. Indeed, he will often overcompensate it. When his ambition is thwarted or his efforts toward success and accomplishment and leadership are too strained, he will have a tendency to run for cover, to slip back into a dependent childlike attitude, to put his thumb in his mouth, so to speak. Now there is reason to believe that these passive, receptive, thumb-sucking cravings, when not satisfied, as they can hardly be in such an upstanding he-man, and when continually repressed, find their expression in a primitive way. Just as anger and fear and pain may express themselves in the form of trembling and pallor and sweating, so the need to be loved and cared for, especially when denied, may express itself as a desire to be fed. The stomach is then constantly alerted and behaves as it does during digestion, continuously prepared for food that it does not receive.

This, in broad terms, is the formulation arrived at by Dr. Franz Alexander⁴ as the result of his psychoanalytic studies of a group of patients suffering from peptic ulcer. It represents, perhaps, only a rough approximation of the truth. No one has as yet conclusively demonstrated that a given emotional constellation is inexorably and uniquely linked with a somatic disturbance. But Alexander's views are challenging and point the way for further investigations.

Dr. Harold Wolff,⁵ in his ingeniously conceived and carefully executed experiments, has borne out in the main the views of Alexander. These experiments were performed on his laboratory assistant, Tom—a modern Alexis St. Martin. Like his famous scientific progenitor William Beaumont, Dr. Wolff observed Tom's stomach through a stoma produced in him surgically, after an accidental closure of his oesophagus, and not as the result of a gunshot wound, from which St. Martin had suffered. Dr. Wolff found that when Tom's hostility or resentment or anxiety was aroused the lining of his stomach became engorged and red, just as would his face. There was a sharp increase of acid production and vigorous muscular contraction of the stomach wall. When the stomach lining is in this engorged state it is unusually susceptible to injury, even the most trifling damage results in hemorrhages and small erosions, and when such an eroded area is deprived of its protective coating

of mucus, an ulcer will form. Dr. Wolff was able to produce ulcers in Tom's stomach, but by covering them with a protective dressing they quickly healed.

Today most internists are impressed with the important part that emotional tension plays in the symptoms of their ulcer patients, and in their response to treatment. Indeed, a strange situation is arising in medical practice. These patients are being referred to psychiatrists for consultation, a state of affairs that usually comes as a kind of shock to the patient who arrives at the consultation bewildered. I saw one such recently. He was fidgety and ill at ease. At the close of the interview he said, "Gee, I didn't know it was going to be like this. I thought you would hypnotize me, or give me one of those new drugs, and get me to tell you something horrible about myself!" Actually, we had discussed his habits of life, his family situation and his work. He was one of those eager, industrious men, always in a hurry, always too early for appointments, never satisfied with himself, a hard player and a poor loser. I think one can say of such a person not that he complains of his stomach, but that his stomach really complains of him. I believe that the two can sometimes be helped to live together on better terms.

I have dealt with the problem of ulcer simply as an example, because some of the best work in psychosomatic medicine has been done in this field.

In the complicated subject of arterial hypertension our understanding of the emotional factors is still far from perfect, and yet their importance is no longer gainsaid by thoughtful clinicians. In a symposium held recently at the New York Academy of Medicine, Dr. Goldring, an internist trained in the laboratory, presented the newer knowledge of the renal circulation and discussed the possible role of pressor substances but concluded his remarks by stating that our best therapeutic tool in this puzzling disease remained psychotherapy. It is not surprising, therefore, that some have attempted to explore the psychological aspects of arterial hypertension: Moschowitz,⁶ Menninger,⁷ Rennie,⁸ Weiss,⁹ Alexander,¹⁰ and Saul,¹¹ among others. In collaboration with Dr. Nathan Ackerman I have myself put in four years at hard labor breaking ground. I cannot say that we struck gold, but I hope at least that we uncovered some facts. These are to be published in a much overdue monograph¹² of which the page proof has finally come through. The work was supported by a grant from the Josiah Macy, Jr., Foundation and was done in cooperation with Dr's. Cohn, Shroeder and Steele of the Hospital of the Rockefeller Institute. I will not now go into details. The investigation was based on the clinical and psychiatric study of 24 patients suffering from arterial hypertension.

The facts that stand out from our own studies and those of others are these: Sufferers from arterial hypertension exhibit a disorder of personality which has been conveniently described by the term "neurotic." This disorder manifests itself in their interpersonal relationships, in their sexual adjustment and often in their occupational achievements. They are characteristically tense individuals given to states of anxiety and depression. Much of their emotional tension can be ascribed to inhibited, but not deeply repressed, aggressive impulses. It is often possible to trace the history of this neurotic development of character to early childhood, when the common feature is an extreme degree of insecurity, with a greatly unsatisfied dependent relationship to a threatening parent. Given this bad start the patient then falters through life—unable to relax, unable to enter into secure and satisfying relationships, always on the defensive, ready to fight, but afraid to fight.

With this precarious adjustment the apple-cart of the patient's emotions is easily upset. The death of a parent, or of a partner, a motor accident, the illness of a child, business reverses—almost any event which jeopardizes his security—which is felt either directly or by implication as a threat to his life—increases to an intolerable degree the quantum of his anxiety and of his reactive depression. In our series of cases it was observed that the clinical discovery of elevated blood pressure frequently coincided with such a traumatic experience.

I do not wish to be understood as stating that this disturbance of character or its ultimate outcome is the cause of hypertension. It is, on the contrary, my suspicion that the psychological disorder and the physiological disorder each represents a different aspect of a more basic disturbance, the nature and cause of which is unknown—though its existence is often foreshadowed early in life.

What therapeutic implications are to be drawn from these observed facts and from this theoretical interpretation of them? The first is that psychotherapy cannot be directed at blood vessels. It can be directed at the emotions. Its aim is to treat the person, not the vasoconstrictor mechanism. This must be kept clearly in mind. What we can accomplish will depend—as in any other therapeutic procedure—not only upon our skill, but also upon the material with which we are forced to deal. In this instance it is not a plastic, easily workable one. These patients have usually extraordinarily rigid personalities. Their aggressions are fixed, they are not fluid or readily mobilizable. If they were, they themselves would have spontaneously found a more satisfactory and less destructive expression for them. Much of their anxiety is absorbed in their symptoms. It is not easily dislodged and when it is it may sweep over them and produce a state bor-

dering on panic. The underlying depression is constantly being fed by the conviction that they are sufferers from a fell malady, that fate has dealt them a body blow. Each symptom winds up the main spring of their tension, increases their anxiety and undoubtedly reflects itself in their vascular apparatus. Deep psychotherapy in this illness is, therefore, no task for the bungler or the amateur. It is as dangerous, as delicate and as difficult as surgery.

Lacking statistical criteria all we can do is to proceed according to certain rational principles. I have stated what they are. The problem is that of treating a severe character neurosis in which anxiety, depression and suppressed aggression are the cardinal psychopathological features. The method of choice will vary from cheerful neglect (based on that much vaunted common sense which we are all supposed to possess in such good measure) to deep psychological exploration. The latter you will grant is a matter for the expert. What is to be hoped from it we cannot say. There is as yet no evidence that psychoanalysis or any other psychotherapeutic procedure can reverse the physiological process or change the destiny of this disease—be it benign or malignant. The problem is an open one. It needs further investigation. The ground has now been cleared for such an undertaking. It is probable that we can do more by way of prevention than cure.

There is, on the other hand, a good deal of evidence that a correlation exists between levels of pressure and emotional disturbance and that suitable psychotherapy can ameliorate some symptoms: such as headache, fatigue, palpitation, dizziness, shortness of breath and the fear which these engender.

We have observed this ourselves and so have others. In a review of the records of 200 consecutive patients with symptoms of hypertension Weiss⁹ selected 144 which, in his words, "seemed to correspond to the clinical picture of so-called essential hypertension." Ninety-three of these lent themselves to satisfactory psychosomatic investigation and in only seven did he conclude that psychic factors bore no relationship either to the onset of hypertension or to the production of symptoms. Case I. of his series shows a quite remarkable coincidence between periods of elevated blood pressure and vasospastic retinitis with anxiety producing episodes and with what Weiss called periods of "throttled aggression."

In Alexander's¹⁰ carefully studied psychoanalytic material he presents blood pressure readings of 161/110 when his patient was emotionally disturbed as compared with 142/98 when calm. Saul¹¹ has made similar observations of changes of blood pressure with mood and, more especially, with

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variations in the intensity of the so-called transference situation. Of course, it must be borne in mind that fluctuations may occur spontaneously without reference to known therapeutic effects.

The most striking, unique and dramatic case in the literature is one reported by Dr. Lewis B. Hill.¹³ This patient recalled early in the course of psychoanalytic treatment a deeply suppressed childhood experience in which his mother struck him with a pony whip. The recall and reliving of this traumatic episode was followed by a critical sustained and enduring fall of both systolic and diastolic pressures. Perhaps this single observation is a prototype of others to come. But, in honesty, it must be said that from a clinical point of view the case is insufficiently documented and the diagnosis remains open to question.

Leaving now out of consideration all efforts at deeper psychodynamic inquiry and turning to the everyday handling of these patients, I believe that our new knowledge can be put to effective use. We are dealing with tender vessels. They need to be protected from emotional strain, especially from demands upon a self-reliance they do not possess. There is no good in telling them to "buck up" and "forget it." They need the maximum of reassurance about the disease itself. They need very much to feel that some one person is watching over them and will take on his shoulders the burdens of their worries. They need to be encouraged to express their aggression, not by hurling dishes or epithets at their wives, but by directed work and play and by physical exercise compatible with their cardiac reserve. They need to be weaned away from an overconcern with the level of their blood pressure. The experienced doctor will vary his methods. With some he will be frank, with others he will be silent and to some he will have to dissemble. The manner in which this frightening fact is first presented to them is of the utmost significance. If the doctor shows his own alarm when the mercury column tops 220 he is apt to communicate it promptly to his patients.

It is well to remember that almost all of our therapy is in essence psychotherapy. Drugs and sedatives, rest and exercise, diet and baths all have psychotherapeutic implications; and this is just as true of surgery. The surgical amphitheatre has become the court of last resort in this illness. Perhaps in time we will learn on what findings nature bases her verdict—why some patients respond to sympathectomy with a reduction in blood pressure, a recession of retinitis and a merciful relief from headache, while others do not. I hope that it will not be thought too "tender-minded" of me if I suggest that the attitude which patients bring to the ordeal of operation may in some measure determine its effects upon them. For there are those who face it as they would doom and there

are others who look upon it as a deliverance.

Turning now to matters equally reconde I should like to touch briefly on the state of our knowledge in allergic reactions and in bronchial asthma. Nothing that we do know about specific allergens or protein hypersensitiveness gainsays the very obvious part that anxiety and other sources of emotional tension play as trigger mechanisms in setting off these pathological responses. The threshold of reactivity may be raised or lowered by the emotions. For example, a woman sensitive to chicken, corn and cabbage and unable to tolerate the presence of dogs and cats was protected by psychotherapy from her usually troublesome reactions to these specific stimuli, even though she did not lose her hypersensitiveness. Some patients with bronchial asthma, as Dr. French¹⁴ has shown, respond admirably to appropriate psychotherapy—especially to a ventilation and abreaction of guilt-laden material.

In the clinical disturbances to which I have alluded—ulcer, hypertension, bronchial asthma—we are dealing with disorders of secretion, motility and the tone of smooth-muscle. In all of them, impulses travelling along autonomic and sympathetic pathways influence the functioning of the effector organs. And in all of them—it is believed—emotional tension, especially that generated by deeply repressed unconscious conflicts, finds escapement by discharge along these pathways—just as grief finds escapement in tears.

Not only such disturbances but any illness, even a so-called "organic" or infectious one, can be legitimately and profitably studied from the psychosomatic point of view. Coronary thrombosis, diabetes, the eczemas, endocrine disorders, rheumatoid arthritis, even tonsillitis and tuberculosis have been so considered. This carries with it no exclusive imputation of "psychogenesis", nor does it pretend to solve, single-handed, the problem of etiology. Its aims are a deeper understanding and a more resourceful therapy.

In conclusion: The pressing demands of military medicine have greatly enhanced the importance of the psychosomatic point of view, as anyone engaged in rehabilitation work will no doubt realize. But it is not without its pitfalls. There is danger that our patients will be subjected to amateurish bungling, meddlesome psychiatry, or on the other hand, to medicine which is slipshod and inexpert. These unhappy alternatives must be avoided by the co-operative efforts of psychiatrists and internists, perhaps eventually by a sounder training in psychiatry for all physicians. How medicine and surgery and the specialties will incorporate and utilize this new knowledge, and what the psychiatrist's role will be in the coming era of medicine, remain to be seen.

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GERIATRICS*

ROGER I. LEE, M.D.

The Author. *Roger I. Lee, M.D., of Boston, Mass. President-elect of the American Medical Association; former President, American College of Physicians.*

IT does not require a statistician or a slide rule to demonstrate the simple facts that the world has more elderly people in it than formerly and that for the next generation or so, the proportion of elderly people will further increase. Furthermore, it makes little difference at what age one arbitrarily designates as the beginning of being elderly. Theoretically, aging begins in the embryo. Certainly one ages with the onset of adolescence. Most women will at least secretly admit that they are no longer young when they pass beyond child bearing. Sports-writers refer carelessly to superannuated athletes of 30 and amazing elderly athletes of 40. The famous Babe Ruth gave up hitting home runs for pay on account of his aging legs in the thirties, I think.

Certainly one does not arrive at the stage of being elderly abruptly. The crop of being elderly was planted long before the harvest. Being elderly has no infallible sign, certainly not such superficial stigmata, as baldness, white hair, arcus senilis, wrinkles, keratoses, etc. If a man is as old as his arteries, how old are his arteries and how do you prove it before the withering process is manifest?

But it is perfectly feasible to take an arbitrary age. Somewhere in the forties perhaps the middle forties, has much to recommend it. That is the age when nature is beginning to institute those changes that will eventually result in the cessation of child-bearing for women. Supposedly men and women are at the top of their intellectual powers in the 40's. Yet there is evidence that some of the special faculties generally reach their peak before the 40's, for example mathematicians and physicists. The chemist may be a little slower in attaining the complete flowering of his powers but he is still young when he comes into the fulness of his powers. Much of the world's best poetry was written by lads in the 20's and the same is true of music. But let's not develop the argument further. The only point worth emphasizing is that, as in every field of medi-

cine, the early stages are the favorable stages for therapy, especially preventive therapy. Of course, old age has certain characteristics which are peculiar to old age but which are not significant in this present discussion. Baldness, white hair are tell-tale evidences that youth has gotten behind us in some way. Such processes are not merely due to birthdays but more conspicuously than in many other signs of age, the factor of inheritance is often very important.

In point of fact of all single factors contributing to longevity, the lack of longevity or the difficulties and afflictions of the elderly, seemingly the most important is heredity. Stephen Smith attained the ripe old age of 100. He thought it was because he was the first health officer of New York but I thought it was because he had more ancestors and collaterals who reached 90 and 100 than there were flies in the sugar barrel.

President Eliot of Harvard College lived to be well over 90 not because he was President of Harvard but for presumably the same reason his sister, who was not President of Harvard, lived to be well over 90. I myself am elderly and fat. Dr. Elliott P. Joslin of Boston worries about me and my untimely and early end. But I have not high blood pressure or arthritis, otherwise I would reduce my work and my weight. My mother is fat and crowding 90. My family does not run to 100, but unless cut off by tuberculosis or cancer, pegs along to the stout 80's. Lest you think I am boasting unduly, I will confess that a little gentle balminess of mind tends to creep on to some members of the family midway in the 80's. I hasten to say that it is not objectionable and makes them cheerful and disinclined to worry over some of the vexatious concomitants of age.

Of course, the reverse of all this is true. We see in certain families, an inheritance of cardio-vascular disease. One has the sense of machines made of poor material, with an occasional well wearing product. As we now view the problem, such instances are fortunate or unfortunate and if they are to be modified will be modified by general measures and not by measures particularly adopted to the elderly.

Likewise there are ailments and lesions that the elderly have and the young do not. It is trite to

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*Presented at the 134th Annual Meeting of the Rhode Island Medical Society, at Providence, on May 16, 1945.

observe with much solemnity that the manifold manifestations of arterio-sclerosis, cataracts of the eyes, gall-stones, diverticulosis, prostatic enlargement and cancer are predominantly conditions which increase in frequency with increasing birth-days. These conditions present diagnostic problems rather than specialized therapeutic problems of geriatrics. To be sure, there are dietary problems in connection with diverticulosis and its control and also in gall-stones. The diet for those so afflicted is the same for any age. That is merely sound medical practice and not particularly geriatric medical practice. Obviously, what needs development is the discovery of factors which will prevent those conditions. While at the moment, it is mostly wishful thinking, yet it is not too far removed from reality to expect for example that the future may produce a something, probably a hormone, that will control prostatic hypertrophy, or the aging of the prostate. One of the most vivid impressions of my life was the sight of an elderly male monkey sitting in a corner of a laboratory and looking thoroughly ashamed because his breasts were full of milk.

Sympathectomy may at the moment be the most effective know therapy for hypertension. It is, however, dealing with an established condition but probably not with the causative factors. I stress this merely by way of illustration. It is all good sound medical practice, but actually not geriatric medical practice.

As I visualize the problems of geriatrics, the basis is control of the usual physiology of aging. Obviously all who are born, must age and must die. Equally obviously the process of aging goes on at a different pace, not only in the human being as a whole, but in the various organs and physiologic systems in the same individual. Theoretically at least, the general physiologic aging process may merely be accelerated. The process may be normal but more rapid. And this may apply to any physiologic system of the whole entity. As I have said before the aging of the hair, that is loss of pigment of the hair or baldness, is a well known sign of the aging process but in general we think it is a superficial characteristic and is ordinarily not related to physiologic aging that is detrimental to well being or life even though it dims our glamour and hurts our pride. It is generally assumed, but not proven, that deleterious aging is usually due to a pathologic physiology, which likewise may be general or may involve a single or several physiologic systems. These are the conditions that ideally we want to prevent and as early as possible. This is indeed virgin soil that has scarcely been touched by medical science. But beginnings of a sort have been made notably perhaps by W. deB. MacNider and others. The practice of geriatrics must en-

visage the goal of prevention, however obscure that may seem now. One may certainly speak of the possibilities of epidemiologic studies of the elderly. After all, the association of rheumatic fever and subsequent valvular heart disease was not apparent at first.

In the practice of geriatrics, there are at least three outstanding therapeutic principles (1) measures designed to retard aging either general or local or (2) the replacement or substitution principle and (3) the stimulation principle.

At this moment we can only indulge in platitudes in regard to the retardation of general or local aging. Of course any machine wears out more quickly by abuse and the human machine is no exception. But disuse, or rusting may also be a factor. It is in this area that the experimental study of the aging process is very promising.

It is likely that the other two principles can engage our attention with some prospect of definite action. However it seems probable that all of these principles are closely related and at times not easily separated.

The substitution or replacement principle can be illustrated by the administration of HCL or pepsin to the individual who has none or too little of these substances in his stomach. Undoubtedly, it is not quite as simple as this. We add thyroid where there is a deficiency in thyroid. But we are treading on uncertain ground here because the inter relation and interaction of the endocrine glands are so complex that even the apparently simple addition, replacement or substitution of a substance that is deficient may have far reaching consequences remote from the organ. Likewise the administration of male or female hormones in appropriate cases is doubtless more than simple substitution or replacement therapy.

Your elderly patient may not be able to secure the benefits of the various vitamins. This may be due to a diet deficient in vitamins. It may, at least theoretically, be due to (A) failure to make these vitamins into such a form that can be absorbed or (B) the inefficiency of the absorbing apparatus.

Probably all the hormones and vitamins have some stimulating effects. But, generally speaking, stimulation is achieved through the agency of the nervous system. We are not so certain nowadays, as were our predecessors, that we can stimulate tissues or their activities by the administration of drugs. The extraordinarily complicated mechanism involved, and the remote responses due to the usual process of normal physiology, is indeed staggering. The example of renal calculi related to tiny parathyroid tumors readily comes to mind. And one may sympathize both with the newspaper and with Dr. Walter B. Cannon when Dr. Cannon was explaining some of the mysterious relationships

between emotions, the suprarenal glands and blood sugar. The best the reporter could do was "Harvard savant declares that rage makes a man sweeter".

Dr. Walter C. Alvarez has been telling us for years that most gastrointestinal disturbances have their origin in the "head". War seems to predispose soldiers to peptic ulcer. John Hunter years ago in speaking of his angina pectoris complained that he was at the mercy of any rascal who chose to annoy him. More or less recently we have acquired a name for this sort of thing. The name is psychosomatic medicine.

But why this long digression or is it a digression? I think not. There is abundant evidence that the will to live has a good deal to do with living. And usually the will to live is related with an objective which may be worthy or unworthy.

It is a commonplace remark that when Mr. So and So gave up his position or retired, he sat around for a while and then died. Was he worn out before he retired or did he rust out after he retired? Doubtless there are ample illustrations of both, although the rusting process may be hard to prove. Of course, there are some individuals who live along perhaps more like vegetables than humans and this seems to be particularly true of inmates of homes for the aged and of those who after a life of what seems like monotonous toil and hardship have an adequate pension for their simple needs. But we must not include in this group those elderly persons who derive such pleasure in making others in the family unhappy. This is one of the unworthy objectives which result in the will to live. I cannot find better illustrations than I have given elsewhere. A woman over 90 took to her bed in 1914 and declared she was about to die. But then came World War 1, in which she took a great interest, which necessitated that she retrieve from downstairs the daily papers. She lived until the end of the War. She was not pleased with the Treaty of Versailles because, as she said, neither it nor the War settled anything. So, once more, she took to her bed some four years older. This time to the surprise of her family she did die. She had lost her incentive. Another lady of over 90 took to her bed on her return from the funeral of her son-in-law whom she disliked intensely. There were financial matters depending on whether she or her son-in-law died first. Having no further objective in life after she had outlived her son-in-law, she promptly died.

The moral, of course, is only too obvious. The elderly require the stimulation of some objective in living. Otherwise they rust. Not always does rust rapidly invade a vital organ and bring on death. But with no objective in living, seemingly life continues as a vegetable existence, or some part

rusts out, resulting in death. I dwell on this because it seems to me to be the most important principle of geriatrics—or the treatment of the diseases of old age.

The prevention of this state goes far back in life, the cultivation of hobbies that can be pursued after active business participation is over, the substitution of some other interest for the dominant interest of a man's life.

I know of a surgeon, who, when he felt that he should retire from active surgery, developed his latent interest in anthropology and in a relatively few years had a more distinguished career as an anthropologist than he had in surgery.

If we are to accept the present trend of retiring executives, professors and some professional men at 60, as well as pensioning workers at 60-70, some provision must be made for these individuals. It may be true that a man on his own farm may merely curtail his activities with his birthdays, but what if he works for some one else? A lawyer may still be an ornament to his firm and be of real value, even with advancing years. And a business man may still keep his office and become chairman of the board. But what of the mill superintendent, the railroad employee and the vast numbers of others. "Doctor, should I retire or resign?" is often a poser. Whatever the answer, there must be a job, an interest in something, a sense of usefulness. Too often the family and the doctor gang up on the elderly man or woman. All agree on the verdict, just age and nothing to be done, except to await the carrying out of the death sentence.

As I have said, true prevention begins a long time before. Also the practice of geriatrics is not the exclusive role of the doctor. The family must help. Once in my interest in this subject I found an answer to the query "And what do you feed the old gentleman on?" He was toothless but spry and alert. "Oh, mostly milk, whiskey and flattery and the last two seem to be the most important. And flattery is almost an essential vitamin, if you will pardon the phrase, for the elderly."

In 1929 an Old Age Counselling Center was established in San Francisco, California. A report in 1942 states that "in 1929 many, in fact, most, of the old men and women who became its members did so with the major interest of finding ways and means of securing financial security." But, although the Federal Old Age Pension was assured and "this in some measure answers the primary need of the old", nevertheless "the idea that with the granting of a pension, a state of physical and mental well-being would result has received a death blow". It is evident everywhere that "those old persons who have more than ample financial security fail to present a picture of happiness and contentment."

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The Teachers Insurance and Annuity Association of New York, in which most educational institutions, like our Colleges and Universities, arrange pension plans with their teachers brings similar evidence. This Association reports that the "financial sub-problem is by no means one that most frequently occasions unhappiness."

We trust that there will not always be a war in which many of the elderly can make dressings and bandages, knit socks and sweaters for soldiers and sailors, become Gray Ladies, act as Air Raid Wardens and the like. The elderly are very like any group of physically handicapped. Both have limitations, obvious as a rule, and usually they are more conscious of these limitations than others. Pasteur did his best work after a partial recovery from an apoplectic stroke. Beethoven composed sublime symphonies when he was deaf and which he never heard. Milton was blind. And the man who died shortly after entering his 4th term as President of these United States had a crippling malady before he was Governor of New York. Within the limitations of their infirmities, the elderly and the handicapped can still live a useful and happy life, but not by waiting for death. Pride, failing self esteem, the fear of being regarded as old and crippled, inhibit these persons often more than their infirmities. Too often these inhibitions turn their minds and their conversation backwards to the days when they too had the insolent pride of youth. Too many of them forget Socrates and long to emulate Mars, Apollo, or Venus and Cleopatra, if you will. They have forgotten that to stand still is to fall behind. As the world moves, they must move with it. But what can be done about it? The testimony is clear that our professors, supposedly intelligent men, are aggrieved, annoyed and even surprised when retirement comes to them at a fixed age. More often than not, no preparations have been made for the age after retirement. Those preparations should be begun in the forties. Most young men give up football in the early twenties. Perhaps they take up golf. But it may be that golf is impossible at 60-70. Your unprepared professor at retirement is almost in the same boat as the thirty year old pugilist or baseball player. The geriatric problem is somewhat similar. Obviously, the solution comes from within, but family friends and the Doctor can help.

Doubtless some of you have been wondering if I consider that geriatrics is confined largely to the male sex. It is true that in the world of today, one sees the problems of the elderly more clearly outlined in men than in women. The man, the bread winner of the family often meets a definite crisis when he loses his job, is retired or resigns. On the other hand, with women whose job has been in the home, the transition is gradual, punctuated, to be

sure, by the death of her husband and the necessity of making readjustments. But those adjustments are often of degree. But the professional woman, the employed woman, has identical problems as the man. The habit of many women of continuing some sort of housework, of knitting, of interest in gardens and flowers, helps the transition. Women have been the ones who go to teas, lectures, bridge parties, etc. It is the contrasting values of the activities of adult and old age that bring unhappiness. It is not a matter of actual values. God knows that many, many women, especially those who are unmarried and those who have no children or grandchildren, and those whose children or grandchildren do not count as blessings, have lived empty lives and being elderly is only the continuation of that emptiness.

And what in particular does it mean to attempt to modify the process of aging, general or local? Briefly, I take it to mean that we encourage the elderly to continue all the activities within the limitations, general and local, of the individual. Certain facts are, I think, obvious. For example, youth can work or play to the point of actual exhaustion, then sleep the clock around and emerge largely restored. In the elderly, the recuperative and restorative processes are much slower. Hence, the old saying he was a young man when he took sick, but an old man when he recovered. The elderly need a fairly even distribution of their activities, punctuated by rest periods. Indeed some of the young elderly can testify to overpowering drowsiness, let us say after lunch, or after dinner, or even during bridge in the evening. But I shall go no further into these domestic intimacies which I am sure are as old as man and woman. I may point out, however, the example of the family dog, who unashamed takes frequent rests, after meals, after exercise, but who is nevertheless ready and eager for a romp or an expedition.

To my mind, the ideal exercise as birthdays increase is walking. For some golf, which is a technic of getting a half hour's exercise in two hours and a half, is excellent. But the golfing ritual of 18 holes, or contemptuously 9, is often too inelastic. Then, too, with elderly, it is undesirable to exercise only sporadically. Rainy week-ends, especially in succession, makes some supplement necessary, even in the summer.

In earlier days, the diet of the elderly was largely decreed by his teeth, or the lack of them.

It used to be said that milk was the ideal food for the elderly. It is an important part of the diet, to be sure, but was never meant to be the exclusive diet of the elderly. The elderly particularly need a liberal mixed diet albeit with a weather eye out to decide how much fat and how much roughage he can take. As I have said earlier birthdays bring

gall-stones, diverticulosis and constipation. And besides gall-stones (or gall-bladder disturbance) fats may not well be tolerated by an elderly patient. Ordinary men find difficulties in handling the amounts of fats readily tolerated by Eskimos. And there may be a difference between animal fats and vegetable fats, and perhaps between animal fats from different sources. We are seeing that now. Much roughage is often not well borne by the elderly. Likewise the quantity of food taken is often as important as the quality. While the elderly vary, it is often amazing how much food the elderly can take care of at breakfast (after the long night fast) and it is often true that a light supper makes a peaceful night. I see no reason for the restriction of protein, especially meat protein, just because a person has birthdays over a certain number. Many elderly patients do well on supplementary vitamins. I confess I admit this with reluctance but it seems to be a fact. If you employ mineral oil in geriatrics it is well to have a look at Vitamin A. Another confession I have to make and that is with increasing inactivity, such procedures modified as indicated, as colonic irrigations at regular intervals are extremely beneficial.

If the elderly machine is to continue functioning it must be nourished by a generous diet, supplemented by vitamins sometimes, perhaps by liver i. m., one of our best sources of Vit. B and not always related to P. P. D, supplemented too by hydrochloric acid, pepsin and other digestic aids, all of which I reluctantly confess.

I believe any machine is better for some use, and use includes physical exercise, preferably as I have said, walking and use certainly includes mental occupation and participation in family and community life. Hearing aids have saved many from the life of a vegetable. Eye surgery has redeemed many. Thyroid medication has helped and unquestionably the administration of appropriate hormones will help more in the future than it has in the past. These hormones should be given to help in the general well being and not for the particular purpose of resurrecting the embers of the sexual past. All living things eventually come to a physical death. The aim of geriatrics is not to drag out an unhappy existence to the last possible second but rather to continue the well being of those whose birthdays increase, so that they may have a full and satisfying life with their fellow men until the inevitable end. Life should have its enduring satisfactions. As life changes, it may be different, but it should not be miserable and useless.

Eventually geriatric practice will be preventive. Experience indicates that financial security is by no means the answer. Jobs, hobbies, equanimity, the philosophic concept of being of some use and of belonging are apparently the fields we must develop.

I shall close with a little jingle that I trust carries a moral. The jingle points out the evanescent nature of many of the youthful activities and the lasting, yes everlasting nature of some occupations of an elderly life.

"King David and King Solomon
Led merry, merry lives,
With many, many lady friends
And many, many wives;
But when old age crept over them—
With many, many qualms,
King Solomon wrote the Proverbs
And King David wrote the Psalms.*

*James Ball Naylor, *Ancient Authors quoted by Ralph Barton Perry in "Plea for an Age Movement". Copyright 1942, all rights reserved.*

NEWER DEVELOPMENTS IN THE ETIOLOGY AND TREATMENT OF DIABETES

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study of our coma cases that if the patient received on the average 83 units of insulin during the first three hours after admission to the hospital for diabetic coma, the mortality was 12 per cent, but if they received 216 units of insulin on the average during the same period, the mortality fell to 1.6 per cent. What better evidence could be desired for the necessity of provisions for laboratory equipment and personnel during every hour in the day in every hospital, so that the diagnosis and treatment of diabetic coma can be prompt.

Pregnancy in the Diabetic. The mortality of a diabetic mother during pregnancy is almost as rare as for a non-diabetic. Until January 1, 1936 the percentage of live babies in the group observed and studied in our clinic by Dr. Priscilla White was 56 per cent, but in the recent compilations of Dr. White this has changed markedly. For the uncomplicated pregnant diabetic, the viability of the child can be expected to be 95 per cent, for the diabetic with abnormal hormones, but without hormonal treatment the viability is 54 per cent, but for such cases whose abnormal hormonal balance is controlled, the viability of the fetus rises to 90 per cent. Space does not allow one here to give details of management of these cases. However in a recent number of the *Journal of the American Medical Association* a paper by Dr. White describing the methods she has employed can be found.*

The responsibility for the control of diabetes rests today as heretofore largely upon the individual patient, but only so provided the hospital furnishes beds and laboratory service for his complications and provided the doctors furnish education along with therapy and prompt action whenever an emergency arises.

*White, P., *Pregnancy Complicating Diabetes*, J.A.M.A., 128:181 (May 19) 1945.

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THE DOCTOR'S PATIENT AND THE WAGNER ACT*

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THE introduction in Congress by Senators Murray and Wagner, and Congressman Dingell, of an act to provide for the national security, health and public welfare, and the subsequent endorsement of that measure with but one reservation by Governor J. Howard McGrath of Rhode Island, prompts me to make the following observations as regards the medical and health phases of the proposed legislation.

First let it be clearly understood that the medical profession does not oppose constructive social legislation properly administered and free of political control. On the contrary, its record through the years has been one of support of any program that concerns the improvement of human welfare.

Nor does the medical profession fear the "socialization" of its membership because of social security expansion that calls for health services. What it does fear, however, is the socialization of its patients—the public—who by yielding certain of their liberties may lose greater liberties, and eventually all. The proponents of the legislation would discount this conclusion, yet the proposed Wagner act shows provision for the creation of a national compulsory sickness insurance system, centralized in our national government, with payments to be made from the national treasury for medical and hospital care rendered to employed persons.

As with all measures proposed for the benefit for the public, it is well for the parties concerned to analyze and to evaluate the legislation before it is enacted. In a matter of such far-reaching importance as the health care of the entire population of this country the question naturally arises as to whether this revolutionary method as proposed by Senator Wagner and his colleagues is necessary in the first instance, and in the second whether it is the best way in keeping with American traditions to achieve the purpose desired.

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The fact that forms of health insurance have been adopted in foreign countries is not sufficient reason to maintain that we should follow suit. In no country is the health of the average citizen more advanced, or better safe-guarded than in America, and in no foreign country has there been established a system of medical education, training and care comparable to ours. Much has been said about the Selective Service physical examinations and of the number of men rejected for military duty. Why were they rejected? Simply because we had the strictest system in the world in our examination of recruits, and thousands of boys were rejected for slight defects, most of which were remediable. Does anyone blame our system of medical care for this failure of individuals to exercise ordinary care of their bodies?

For years we have had excellent clinics, manned by the very doctors that the Wagner act would regiment, where medical men have given of their time and experience without remuneration and at no expense to the patient. What we have too often lacked have been laws that would compel some of these very patients to obtain treatment and safeguard their lives and the lives of their families and associates. The patient on ward service today receives equally as good medical care as any other patient. The thousands of wives of servicemen who have been recipients of benefits under the emergency maternity and infant care program can attest to that.

As a profession we are in agreement that something should be done to assist people to budget for their medical and hospital care expenses. The problem is one of economics, and we have been most willing to assist in the solution of the question. We have supported the progress of Blue Cross hospitalization plans since their start, and we are now engaged, as are many other medical societies, in working out a parallel program to provide surgical, and eventually medical benefits on a voluntary prepaid insurance basis.

Is There Free Choice of Doctor?

The adoption of the Wagner act as now written, as I view it, would not only result in the public not getting as good care as they are now receiving, but I fear it would deteriorate to the level of the so-called lodge patient, and the system of taking care of the ward patient would be destroyed in the bargain.

Let's take a moment to see how the eligible citizen would actually fare, according to this legislation, when he is ill and has to see a doctor.

In return for the compulsory tax taken from his wages the *eligible* sick worker would be entitled to the services of "general or family practitioners" who have agreed to participate in the program and who have agreed to have their names listed. If he wishes any other physician not listed the sick worker would forfeit his claims and would have to pay for the entire fee himself. If his illness required the services of a specialist the same procedure would hold, with the added provision that "such services shall *ordinarily* be available *only* upon the advice of the general or family practitioner or of a specialist or consultant attending the individual." (*underscores mine*).

In our competitive society we tend to seek the best service. However, the best doctors would not be available to anyone under this legislation, for provision is made that the Surgeon General may "prescribe maximum limits to the number of potential beneficiaries for whom a practitioner . . . may undertake to furnish general medical or general dental benefit, and such limits may be nationally uniform or may be adapted to take account of relevant factors."

Thus the individual may wake up, once such an act is passed, and find that the physician in whom he has confidence, whether he is called the family physician or not, or whether he is a general practitioner or a specialist, is not available to him. The situation is somewhat parallel to that of the maternity care program supported by the federal government for wives of service men up to the grade of sergeant, in which free choice of doctor was advertised by the federal agency, and free hospitalization. When the beneficiary sought the care, very often few doctors were available for the service, and the hospital care was restricted to ward accommodations with the condition that any payment of better services would result in forfeiture of all federal benefits.

And as a further restriction the measure proposes that the Surgeon General, after consulting with his Advisory Council which has no authority itself, may, with the approval of the Administrator of the Social Security program, determine that every individual entitled to medical, dental or home nursing benefits "shall pay a fee in respect to the

first service or with respect to each service in a period of sickness or course of treatment. . . . Such determination may also limit the application of such fees to home calls, to office visits, or to both," all for the purpose of preventing abuses.

One section tells about the enormous amounts of money to be spent in building hospitals. Even if such sums were granted to the States, does anyone think for a moment that the central government in Washington would not exercise a direct control on the program at all times? At present and for many years ahead we will not have enough doctors to man these proposed hospitals. Although some might disagree with me, yet I feel that the federal government might well assist some of our poorer states where hospital and medical care facilities are lacking. But I do not feel that the whole system of medical and hospital care throughout the nation should be jeopardized to accomplish this work.

Regulations by Administrative Law

All this is set forth in the act. But what is not known is the extent of administrative law that would be established as the result of the provisions giving to the Surgeon General and the Social Security Board authority to supervise the national health service program. The public, even more so than the physicians, would feel the brunt of the rules and the regulations imposed to preserve the solvency of the fund, to regulate the available physicians from whom the sick worker might seek care, to determine the amount and duration of benefits, and otherwise to regulate the individual's claim for services for the tax he would be compelled to pay annually.

The medical profession, in maintaining the advantages of private practice, upholds the principle of free choice of physician and a personal patient-physician relationship. It also believes that the voluntary methods of meeting the economic problems incidental to good medical care should be fully explored and promoted before a compulsory program, national or state, is imposed on the people. We know that the present problem is twofold. It concerns itself first with the extension of modern medical science to people everywhere in the country, and secondly, it concerns itself with how to enable the patient to meet the cost of treatment without imposing upon him a serious burden.

We are trying to meet both these issues. Here in Rhode Island we now have a committee studying plans for a prepaid voluntary medical and surgical insurance plan similar in operation to the Blue Cross hospitalization program. We have supported the progress of the Blue Cross and the response here to this plan is ample indication to us that the public is not only willing, but anxious to meet the cost of health care without depending upon public

continued on next page

tax funds, whether accruing from a compulsory social security tax or otherwise. Proponents of the new social security legislation are inclined to belittle voluntary methods for meeting current socioeconomic problems. They would deprive the individual of his personal responsibility and they would transfer it to the entire people where it does not belong.

A physician is an individualist and always will be. He is attracted to the profession knowing he will be able to pursue his studies, experiments, investigations and practice unhampered. Under a compulsory system, as proposed by the Wagner act, it would not be long before a less competent type of doctor would appear on the scene, for initiative would be destroyed, and instead of attending medical meetings, clinics and post graduate courses, the doctor would be forced to court the good will of his local political representatives and the administrators of the health insurance system.

Through the years the medical profession has been quick to adopt any tested new method to aid the public, incorporating it with the practice of medicine. I am sure that if the profession felt that the health and welfare of the public would definitely be benefited by the Wagner act they as a body would be wholeheartedly behind it. All we ask now is the opportunity to present plans for medical care such as Blue Cross has done for hospital services, on a voluntary basis.

It is for such reasons that we take a negative viewpoint regarding the Wagner proposal. I repeat—we are not opposed to health insurance as such. We are, however, critical of the way in which it will be administered. We want the continuance of medicine of quality, and we don't want quality sacrificed for quantity to the detriment of the people who actually need medical care.

Role of Preventive Medicine

One of the major fallacies in most discussions of health insurance by popular writers and social security planners is that they advance health insurance and medical care as the only requisites necessary to make all of us healthy. It is not as simple as that. As every physician can attest, most patients come for curative treatment, not preventive medicine. Most people, ignoring the present day tempo of living—and I refer to pre-war periods also—place too great a strain on the human body. We live in a mechanical age, an age of speed and excitement, an age when we take limited exercise, even walking, an age in which we subject our body to an abuse that too often even the best medical treatments cannot repair.

Regular physical checkups, or early diagnoses of threatened illnesses would do much to lessen the cost of medical care. But human nature being what it is we find that the average person postpones

seeking medical attention until he himself is convinced by pain, or otherwise, that his physical well-being is endangered.

All the health insurance schemes to distribute medical care on a wider scale will not substantially raise the health of the majority of the people unless we solve the fundamental causes of much sickness. Lack of proper sanitary facilities has been responsible for more illness than almost any other single factor. We know from reports that there are many sections of this country where sanitary facilities are deplorable. Even in our own state of Rhode Island, which, as Governor McGrath pointed out in his Mackinac address, ranks eight in per capita income, there were 46,766 dwelling units (23.8% of the total) with no private bath, according to the 1940 U. S. Census.

We have witnessed attempts for years to secure action by Assembly vote to eliminate the pollution of the waters of the State. Recently the health hazards of smoke in the city of Providence were brought to the attention of the public by the Providence Medical Association. These are but additional instances of contributing factors to sickness that can be eliminated, and that will continue to add to the cost of health care as long as they remain unattended.

Health education for the individual is on a hit or miss basis in Rhode Island for the most part. Private and community social agencies have performed yeoman work, and have contributed greatly to the efforts of the state health department. Efforts to establish a statewide school health education program have been balked by local communities for years, and yet a great deal of the ill health has been traced directly to personal neglect on the part of the people who have little or no conception of the importance to themselves of the need for continuous care of their bodies. The Selective Service physical examinations revealed in a convincing manner the need for a vast amount of educational work to counteract the neglect stemming from ignorance or lack of training in the simplest rules of hygiene.

We have reason to be concerned about our eating habits, as research in nutrition has shown us in the past few years. We have learned much in the past decade about child care. We have become increasingly conscious of the importance of recreation and physical exercise, of improved living conditions, and of many other factors that assure a healthier life and that lessen the incidence of illness.

Until these problems are vigorously attacked, until living conditions are improved for all people, and until all are better taught to take care of their personal health, a compulsory health insurance plan having as its objective the extension of medical services to restore persons to good health is but a palliative, not a cure of the problem.

CONSTRUCTIVE PROGRAM FOR MEDICAL CARE

AMERICAN MEDICAL ASSOCIATION

This platform was adopted by the Council on Medical Service and Public Relations and the Board of Trustees of the American Medical Association on June 22, 1945.

Preamble

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of humankind. Science, as history well demonstrates, prospers best when free and unshackled.

Program

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives:
2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.
3. Increased hospitalization insurance on a voluntary basis.
4. The development in or extension to all localities of voluntary sickness insurance plans and provisions for the extension of these plans to the needy under the principles already established by the American Medical Association.
5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.
6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.
7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies

of the states involved with the help and advice of the medical profession.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

13. Adoption of federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical personnel requirements with special reference to the needs of the veterans' hospitals, the regular army, navy and United States Public Health Service.

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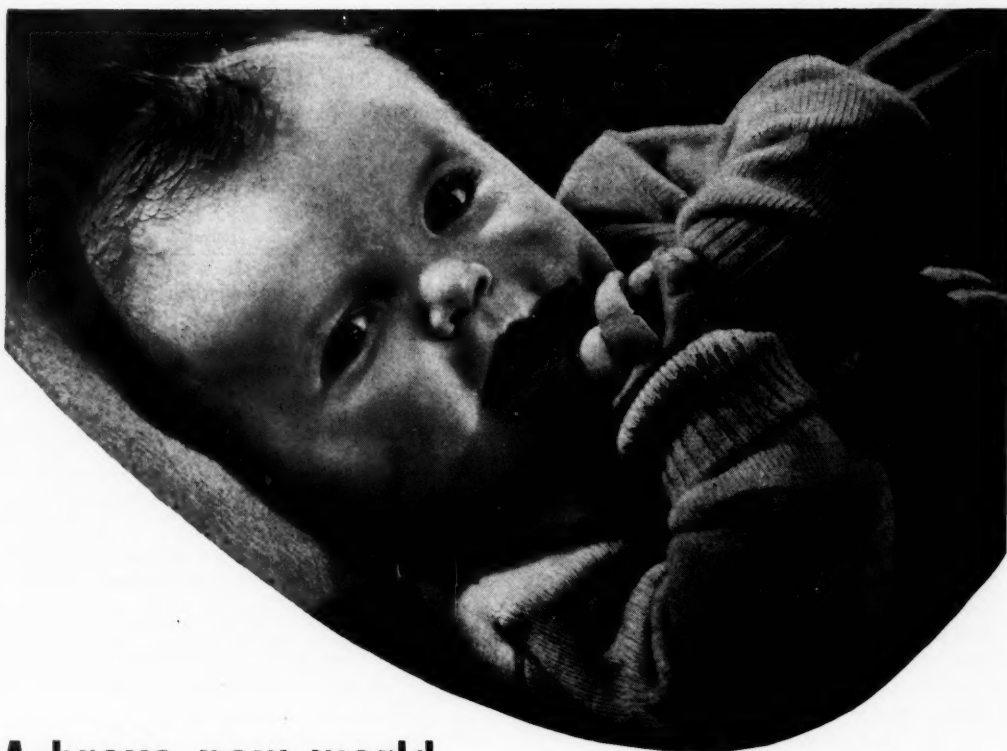
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BLUE CROSS PROVIDES A SERVICE

STANLEY H. SAUNDERS

(Executive Director, Rhode Island Blue Cross)

WHEN Blue Cross was first established in Rhode Island six years ago, none of the men who helped to organize the plan of non-profit hospitalization ever dreamed that the program would embrace over 300,000 subscribers.

The 300,000 mark is but a milestone. It does not entirely measure the growth of voluntary hospitalization. Financial stability and increased benefits do not tell the whole story, either. To fully understand it, it is necessary to know the problem that faced Blue Cross and the planning and study that went into the solution of the problem.

Voluntary hospitalization programs should be set up to cover, insofar as possible, all classes of people within a geographical unit. When the Blue Cross was established in Rhode Island many leading physicians and other outstanding citizens expressed the opinion that the idea of prepaid hospitalization was sound but indicated a belief that it would appeal only to those in the so-called middle-class group who would be able in most cases to pay their own hospital bills. In short, many serious thinkers doubted that those in the lower income brackets who are in the greatest need of the type of care that voluntary hospitalization plans provide would ever be covered by Blue Cross.

The threat of compulsory hospitalization made it clear to industry and Blue Cross alike that if the masses of people were to be reached on a voluntary basis, the wholehearted cooperation of industry would be necessary. It was decided that if a plan sufficiently attractive and low in cost could be devised, the backing of industry could be secured.

Blue Cross attacked the problem by providing a plan with more liberal benefits than ever before offered by a similar organization and at a rate lower than previously considered possible.

Blue Cross called it the Comprehensive Plan.

It was presented to industry and recommended that the employer provide coverage for every employee at a cost of 75c monthly and that the employee, in turn, be encouraged to provide protection for his wife and dependent children at a cost of 75c monthly to himself.

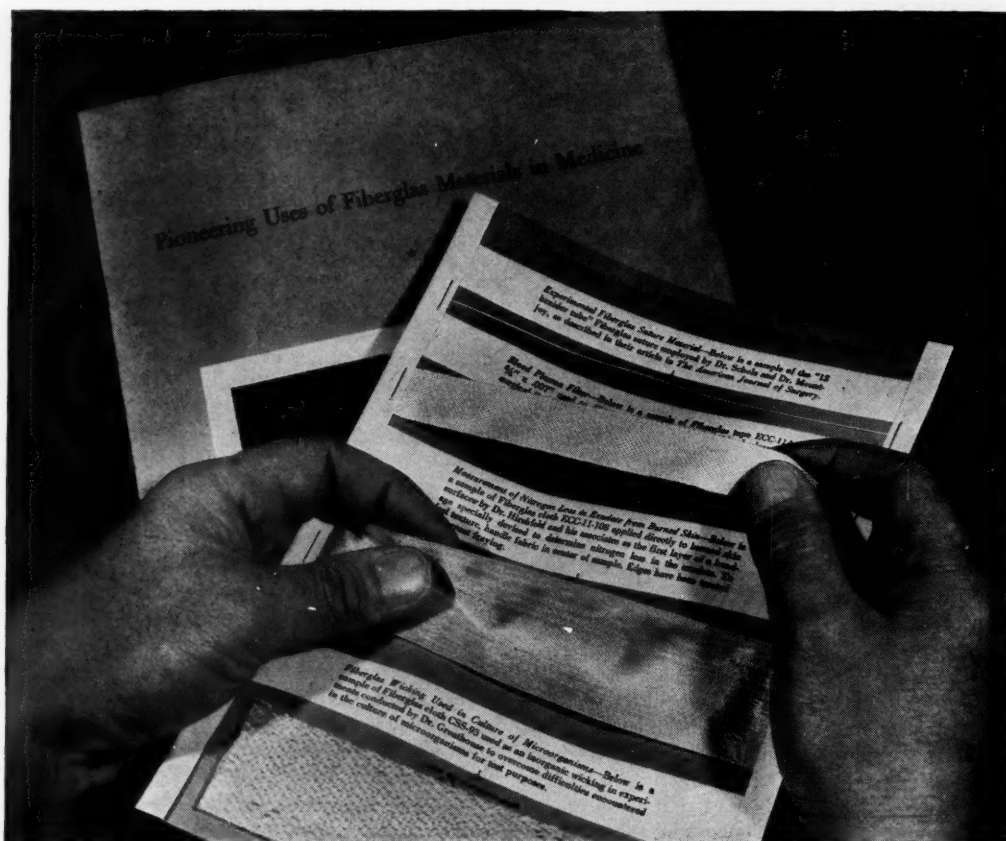
The response to this plan has fully justified the hopes placed in it and its acceptance by Rhode Island industry has been truly remarkable. Within ten months the enrollment under the Comprehensive plan is 23% of total Blue Cross group membership in Rhode Island. Hundreds of employers, many of them representing the largest industries, have installed the Comprehensive Plan.

This means that practically 100% of the employees in 65 textile mills, in 35 jewelry establishments, and in 25 department store, banking, and insurance firms now have the liberal benefits of the Blue Cross Comprehensive Plan. Many of these employees are those who might never have joined Blue Cross. These include younger employees, just out of school, and those who, while they might feel they couldn't afford Blue Cross protection, are actually those who need it most.

Because industry and Blue Cross worked together, these employees have been provided with the most liberal benefits possible. The benefits are remarkable: they include up to 150 days of hospitalization annually, no waiting period for maternity cases, no age limit, and lower cost per member. Pre-existing health conditions are covered; room and board is provided up to \$6 daily; and in member hospitals, the meals, medicines, operating room, laboratory examinations, oxygen and serums, basal metabolism and physical therapy expenses are covered in full.

Granted that this new program was introduced in wartime. Now, however, that the plan has been installed, employers and employees alike will be loathe to relinquish it. Its value will be demonstrated; in better working conditions, greater hospital benefits, and an opportunity to do better work without the worries of unexpected hospital bills.

Blue Cross took a long step forward when it offered this program. It did it because it was conscious of a need, because it had the implied cooperation of industry. Alert to the needs of the times, Blue Cross celebrates its sixth anniversary with 300,000 members because it is constantly striving to offer further service to the people of the State who made its existence possible.



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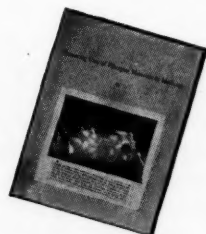
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INDUSTRIAL ACCIDENTS

(A comparative study of the accident record at the Collyer Insulated Wire Company, Pawtucket, R. I.)

CHARLES L. FARRELL, M.D. and HAROLD STANZLER

The Authors. Charles L. Farrell, M.D., President, R. I. Society of Industrial Physicians and Surgeons, and Medical Director, Collyer Insulated Wire Co., Harold Stanzler, Personnel Director, Collyer Insulated Wire Company, Pawtucket, R. I.

A RECENT study of the accident record for the first six months of 1945 compared with the first six months of 1944 and 1943, was made at the Collyer Insulated Wire Company covering three plants. The plants are in Pawtucket and Dartington, one in Central Falls, and one in Providence. This report has just been issued by Harold Stanzler, Personnel Director, and Charles L. Farrell, M. D., Medical Director. It shows a lost time reduction of accidents by over 50% in the first six months of 1945 but an increase in the accident severity rate. The report states, "This might lead one to believe that although we are having fewer accidents they are much more serious ones. However, this is not the case. The sixteen accidents we had were practically the same types of accidents we are having right along. We believe that the Rhode Island Cash Sickness Law which pays sick insurance compensation to injured people in addition to cash benefits received from Workmen's Compensation is encouraging malingering. To cite a typical example: An employee with a fractured toe in 1943 would normally lose from six to eight weeks' time with a minimum of perhaps ten weeks. In 1945 we had an employee with a fractured toe who stayed out over twelve weeks. The average number of days lost has gone up from 10 per accident in 1943 to 40 per accident in 1945."

First 6 months of 1945 compared with first 6 months of 1943-44.

Number of Lost Time Accidents — Frequency Rates

All Plants:	1943	1944	1945	1943	1944	1945
	64	37	16	45.6	25.4	13.5

A comparison of the accident records shows a favorable downward trend during the last two years. There was a reduction of 42% in lost time accidents for the first six months of 1944 over 1943 and a 60% reduction in 1945 over 1944. These percentage figures, however, are not true figures since they do not take into consideration

a reduction in employees and fewer hours worked thus reducing the exposure to accidents. A truer comparison may be made from a study of the Frequency Rates which shows the number of accidents per million man hours worked.

Number of Temporary Accidents — No Lost Time

	1st 6 months 1944	1st 6 months 1945	% Reduction
All Plants Except Providence	176	64	60

There was an overall reduction of 60% also in the number of no lost time accidents which required the services of a physician. These are accidents which require medical attention, but the employee is able to return to work without losing time.

**Comparison of Number of Days Lost
Due to Accidents in First Six Months**

	1943	1944	1945
All Plants	668	1004	640

**Summary of Accidents and Days Lost
For All Plants — First Six Months**

	1943	1944	1945
Number of Days Lost Time Accidents	64	37	16
Number of Lost Due to Accidents	668	1004	640*
Average Number of Days Lost Per Accident	10	27	40

*This figure does not include six months time lost for two men who were injured in 1944 but who are still out on compensation. If this additional time was figured in, the average lost time per accident in 1945 would be 60 days instead of 40.

This summary clearly indicates that employees are reluctant to return to work as long as cash benefits in the form of cash sickness insurance plus disability compensation continues to roll in. It has been frequently asked why doesn't the physician terminate the case. Those of us in industrial practice realize fully the inability of the physician to tell a patient he is well healed and must return to work when the patient limps in with a toe or foot and insists that he is not yet ready to work; that he cannot stand the full weight of his body on the foot and that it hurts to walk.

It is difficult or impossible for a physician to insist that the patient could return to work if the patient is inclined to say his back hurts when bending; he can't sleep nights and that he is uncomfortable and couldn't possibly continue his work. In the face of such statements, the physician

continued on page 665



TRIUMPH OF

DILANTIN SODIUM

INDUSTRIAL ACCIDENTS

concluded from page 661

is bound to go along with the patient and to continue treatment.

It is a definite fact that previous to the institution of the Cash Sickness Law a patient could be examined by a consultant from the Insurance Company who would set a maximum time for benefits and when those benefits had ceased the employee was usually willing and able to go to work. Now the picture is completely changed. It is about time that some drastic action be taken to prevent malingering. The Medical Society has previously suggested that the legislature discontinue the practice of double payment of Cash Sickness when persons are receiving Compensation Benefits.

A CRITIQUE OF PSYCHOSOMATIC MEDICINE

concluded from page 646

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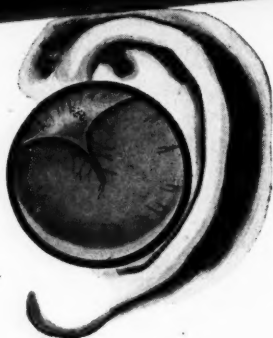


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LT. COMDR. ORLAND F. SMITH, MC, USNR, of Pawtucket, is one of the many Rhode Island physicians who carried the battle to the heart of the Japanese empire, and in a recent communication he reports an interesting tour during which a mine blew up close to his ship, and a couple of days later he had the experience of outsailing a typhoon. Working on a hospital ship, Comdr. Smith reports that "it is quite a sensation to have the big guns of our fleet firing over us while we are receiving patients." At the last writing Doctor Smith was stationed in the Philippines. . . . *LT. COMDR. WILLIAM J. SCHWAB, MC, USNR*, of Providence, in on the Okinawa battle, is now a medical officer in troop transport service and recently returned to the far Pacific theatre of action. . . . The last we heard of *LT. COMDR. JOHN W. HELFRICH, MC, USNR*, of Westerly, was that he was in charge of a 600-bed hospital in the Tinian Islands. . . . Sometime ago we received an interesting report from *LT. COMDR. BANICE FEINBERG, MC, USNR*, which gave us an insight into what a pediatrician does in the Navy. Since leaving the States Comdr. Feinberg has been across the Pacific three times, the last time by air, when he had the experience of seeing the plane run into motor trouble 200 miles from Truk, necessitating a return to Kwajalein where "we landed with about enough fuel left to fill our cigarette lighters."

Comdr. Feinberg furnished an interesting report of his experience with Jap prisoners — but let him tell it to you as he did to us:

"I also had the doubtful privilege of escorting 120 Jap prisoners to Hawaii. I found them very cooperative, very appreciative of every attention, very courteous, and also very sick. While very wiry and agile, yet many of them had tuberculosis, deficiency diseases, especially beri-beri and malnutrition. Despite it all, in their back yard I wouldn't trust them an inch. Their ignorance of the outside world is amazing.

"When we anchored in one of our atoll-lagoons where we had only the average number of ships,

merchant ships, destroyer escorts, patrol craft, destroyers, carriers, etc., they were amazed and were sure we were in Pearl Harbor. It was difficult to disillusion them. However, when we did get into Pearl Harbor we slipped in next to one of our newest, biggest battle wagons and surrounded by war craft of every description. When they saw that, the slits they use to see them just stretched and finally one of the Japs who spoke a little English said to me 'we no win, now'."

LT. NICHOLAS A. POURNARAS, MC, USNR, of Block Island, must have been right at home in the matter of island invasions in the Pacific after making the crossing from Point Judith to New Shoreham for many years. Comdr. Pournaras, attached to the 4th Marine Division, landed with his battalion on Iwo Jima, no new task for he had previously been at Roi-Namur, Tinian, and Saipan. . . . From New Guinea the executive office of the Society had an interesting letter some time back from *MAJOR MORRIS BOTVIN, MC*, of Providence, chief of the EENT service in the general hospital there, reporting of discussion groups in the jungles on the question of socialized medicine. Particular concern was expressed over what was being done at home, with the result that several of the medical officers decided to write to their various medical societies for information.

After service in the European theater, and a tour of duty in the States including special training at the Mayo Clinic, *LT. COMDR. WALTER FITZPATRICK, MC, USN*, is in the thick of the Pacific struggle. His last report told of his trip out of San Francisco to a spot "west of the date line and north of the equator". Add to that the fact that he is in a combat zone and you know he is there in action. Living in tents, eating K and C rations, bathing, showering, shaving and washing clothes in helmets is indeed a far cry from Newport on the shores of the Narragansett. En route out Comdr. Fitzpatrick reported a meeting with *LT. FRED RILEY, MC, USNR*, of Cranston, at Pearl Harbor.

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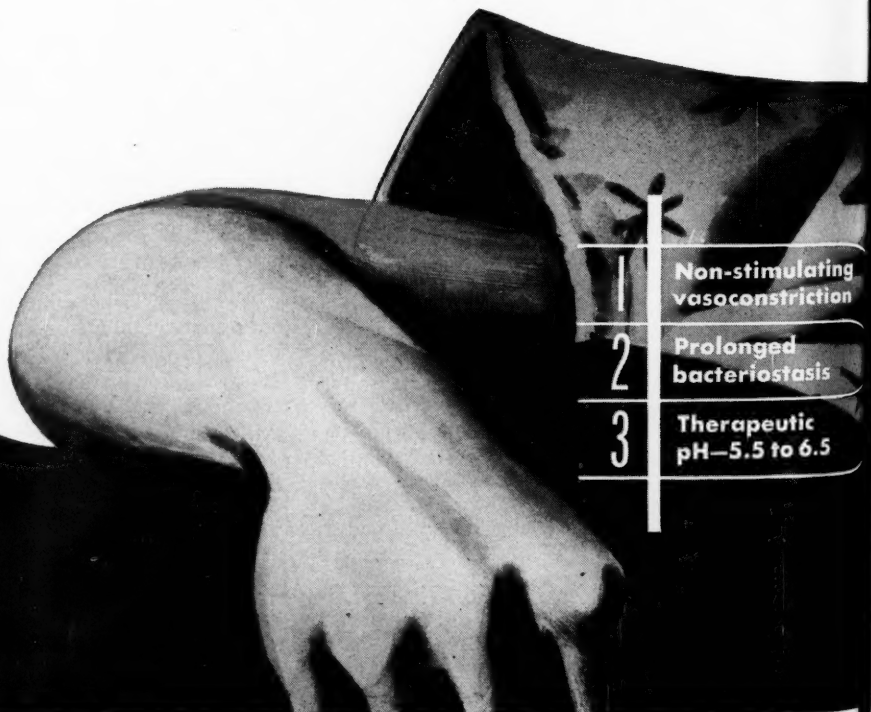
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2. Provides prolonged bacteriostasis. Paredrine-Sulfathiazole Suspension covers the nasal mucosa with a fine, even frosting of free sulfathiazole, which does not quickly wash away, *but keeps producing bacteriostatic action hour after hour.* (An objection to solutions of sodium sulfathiazole is the improbability of their remaining in contact with the mucosa long enough to be effective.)

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PAREDRI—SULFATHIAZO



- | | |
|---|-------------------------------------|
| 1 | Non-stimulating
vasoconstriction |
| 2 | Prolonged
bacteriostasis |
| 3 | Therapeutic
pH—5.5 to 6.5 |

DOCTORS AT WAR

*concluded from page 671**Calling the Roll*

DR. GORDON E. MENZIES, of Wickford, promoted to Lieutenant Colonel this Spring, and stationed at the Seymour Johnson Field in North Carolina, has been subject of a petition by residents of South Kingstown who want him returned to the community for needed civilian service. . . . CAPTAIN MARK A. YESSIAN, MC, of Providence, who was in on the early invasion of the Philippines, sustained a severe knee sprain which hospitalized him for a time. . . . COL. HERMAN A. LAWSON, MC, of Providence, back from his post as head of the 48th Unit in Burma, has been assigned as medical officer at the hospital at Palm Springs, California. . . . LT. E. F. RUHMANN, MC, USNR, of Cranston, who participated aboard an LST in the invasions of Sicily, Salerno and Anzio, spending 65 days at the last named beach-head, and later was at a hospital at Oran where he met LT. COMDR. ERNEST D. THOMPSON, MC, USNR, of Providence, is stationed at Melville (R. I.) Naval Torpedo Boat Center according to our last report. . . . MAJOR F. H. CHAFEE, MC, of Providence, has been returned to the States after lengthy service in the European theater. . . . CAPTAIN EDWARD B. MEDOFF, MC, of Woonsocket, was last reported in the region of the Bavarian Alps with the Seventh Army. . . . LT. ROBERT RIEMER, MC, former RIH intern from East Providence, is with the 9th Evacuation Hospital (a Roosevelt (NY) Hospital affiliated unit) in Europe, but he anticipates a transfer to the Pacific theater. . . . MAJOR MORRIS GROVER, MC, of Providence, recently awarded the Bronze Star, was last reported at an Assembly Area in France awaiting a possible trip home for re-training and shipment to the Jap war front. Major Grover, assigned to an Armored Division, has reported that his travels throughout Europe indicate "a great need for adequate medical care in all parts of the Continent. This is especially noticeable where thousands of ex-slave laborers and displaced allied nationals are present. . . . Medical department officers who have been interested in and concerned with the disease problems among refugees and displaced personnel are inclined to view with a great deal of apprehension the prospects of severe epidemics sweeping the afflicted countries during the coming fall and winter."

It is now LT. COL. RALPH RICHARDSON, MC, for the son of the R. I. Hospital superintendent has been promoted and assigned as chief surgeon in charge of general surgery in a 750-bed hospital in England. . . . If there is one Providence physician whom we never expect to hear

complain about the rigors of our New England climate it is CAPTAIN CLARENCE J. RILEY. A recent letter from Doctor Riley brings the information that he is still in Iceland, but has been transferred to the 92nd Station Hospital and assigned to surgery. He has high hopes of eating his Thanksgiving dinner in Rhode Island next Fall, and he reports a couple of St. Joseph's hospital, and later Chapin hospital, nurses stationed at his hospital. . . . MAJOR BENJAMIN SHARP, MC, of Providence, is on temporary duty at the Veterans' Bureau Office in Providence servicing veterans for this district.

WHO PAYS?

There seems to be some confusion even in the minds of State Governors as to who would pay the cost of the proposed Wagner social security program. Governor McGrath at Mackinac Island, for example, declared: "From my experience in Rhode Island, which ranks number eight in per capita income, I am convinced that only two or at best, three States in the Union, would be financially able to put into effect, alone and unaided, such a broad program as the Wagner bill embraces."

There is no telling how much the state government of Rhode Island could raise for such a program. But it is clear that the people of Rhode Island would pay more for the operation of the Wagner plan under Federal auspices than they would if it were under State management. For as Mr. McGrath explained to his fellow-Governors, Rhode Island happens to be one of the States that would not only pay its own proportionate expense but would also contribute enough additional money to give the poorer States the same benefits as the wealthier States.

The Federal Government, of course, has no money to underwrite the Wagner program except as it collects taxes from the people in the various States or capitalizes the public credit. The end result is the same in either instance. The money comes out of the pockets of the people. And a Federal Wagner plan, as outlined by Governor McGrath, would take more money out of the pockets of Rhode Islanders per person than it would from the people of many States that rank less than "number eight in per capita income."

— Reprinted from the Providence Evening Bulletin, July 9, 1945

In the Activity of the Endocrine Glands

The depth to which protein permeates the fabric of metabolic life, and the role it plays as "raw-material" and component of elaborated secretions is indicated in hormonal composition.

Thyroxine, the active principle of the thyroid gland, is an iodinated phenyl-ether derivative of the amino acid tyrosine. Epinephrine, the active principle of the adrenal medulla, is also a tyrosine derivative. Insulin, as elaborated by the islands of Langerhans, has been isolated in crystalline form and found to be a protein.

Only from the proteins of the foods eaten can the organism derive the protein substances required for these complex purposes.

Among man's protein foods meat ranks high, not only because of the percentage of protein contained, but principally because its protein is of highest biologic quality, applicable wherever protein is required.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



A M E R I C A N M E A T I N S T I T U T E

MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

RHODE ISLAND CASH SICKNESS COMPENSATION FUND

Statement of Receipts and Disbursements June 1, 1942 to June 30, 1945

Submitted by Rhode Island Unemployment Compensation Board

	Receipts	Net Benefits Paid	Transfer to Admin. Account	Refunds of Contri- butions	Interest & Costs on Purchase of Investments	Balance at end of month
1942						
June	84.99					84.99
July	130,314.20					130,399.19
August	285,535.51					388,934.70
September	8,857.15			.68		397,791.17
October	226,547.58					624,338.75
November	942,947.39					1,567,286.14
December	17,305.73			64.94	1,360.00	1,583,166.93
1943						
January	184,670.31			81.24		1,767,756.00
February	892,863.97		15,845.92			2,644,774.05
March	15,647.21			483.93		2,659,937.33
April	450,410.39	120,547.97		1,348.57	119.56	2,988,331.62
May	733,230.88	265,233.32		2,483.39		3,453,845.79
June	26,076.21	450,565.97		1,725.18		3,027,630.85
July	354,940.75	354,222.52		1,498.69		3,026,850.39
August	893,446.82	403,310.10	22,832.55	505.92		3,493,648.64
September	13,728.21	357,446.55		441.82		3,149,488.48
October	306,597.25	298,212.04	12,621.16	27.39		3,145,225.14
November	813,505.37	313,407.87				3,645,322.64
December	26,739.01	294,222.04		820.89		3,377,018.72
1944						
January	331,288.95	288,082.99		2.60		3,420,222.08
February	711,224.16	304,062.08	11,270.04	427.76		3,815,686.36
March	19,737.82	324,997.31		9.68	240.05	3,510,177.14
April	497,163.80	347,469.76	10,602.33	300.70	-80.02	3,649,048.17
May	714,511.59	598,691.00		6,092.58		3,758,776.18
June	22,871.05	629,753.00	68,973.88	2,608.16		3,080,312.19
July	536,426.78	521,233.50	36,235.96			3,059,269.51
August	652,625.83	526,306.25		931.39	80.03	3,184,577.67
September	11,774.10	408,754.25		1,859.53		2,785,737.99
October	419,054.70	409,687.75	35,875.43	544.60		2,758,684.91
November	679,346.34	376,449.87		536.10		3,061,045.28
December	27,995.75	299,187.74		161.81		2,789,691.48
1945						
January	275,963.89	336,045.64		193.13		2,729,416.60
February	687,564.82	279,488.25	33,265.41		76.80	3,104,150.96
March	19,300.50	357,327.50		670.18		2,765,453.78
April	363,260.49	373,737.96	29,456.67	5,312.87		2,720,206.77
May	890,265.89	566,351.00		1,102.83		3,043,018.83
June	28,901.69	495,147.50		828.20		2,575,944.82



How comfortable can a cold be?

The sneezes and the snuffles usually run their course . . . but a few drops of Sulmefrin make breathing easier and bring quick comfort. Nasal congestion is relieved and the danger of sinusitis and other bacterial infections considerably lessened.

Sulmefrin is a stabilized aqueous solution of an effective vasoconstrictor—*dl*-desoxyephedrine hydrochloride (0.125%)—plus sulfathiazole sodium (2.5%). Mildly alkaline, non-irritating, Sulmefrin does not impede ciliary action. Administered by spray, drops or tamponage.

SQUIBB

Sulmefrin
TRADEMARK

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

UNIVERSITY, HOSPITAL AND MEDICAL SOCIETY RELATIONS

ALEX M. BURGESS, M.D., *Chairman*; B. EARL CLARKE, M.D., HARMON P. B. JORDAN, M.D.

As the result of a questionnaire circulated by the Society through the Committee on University, Hospital and Medical Society Relations many additional names have been added to the roster of physicians willing to serve on the Faculty of the Society to carry out the post graduate teaching plan proposed. (See R. I. Medical Journal of February, 1945). The names of doctors and their subjects not previously published are as follows:

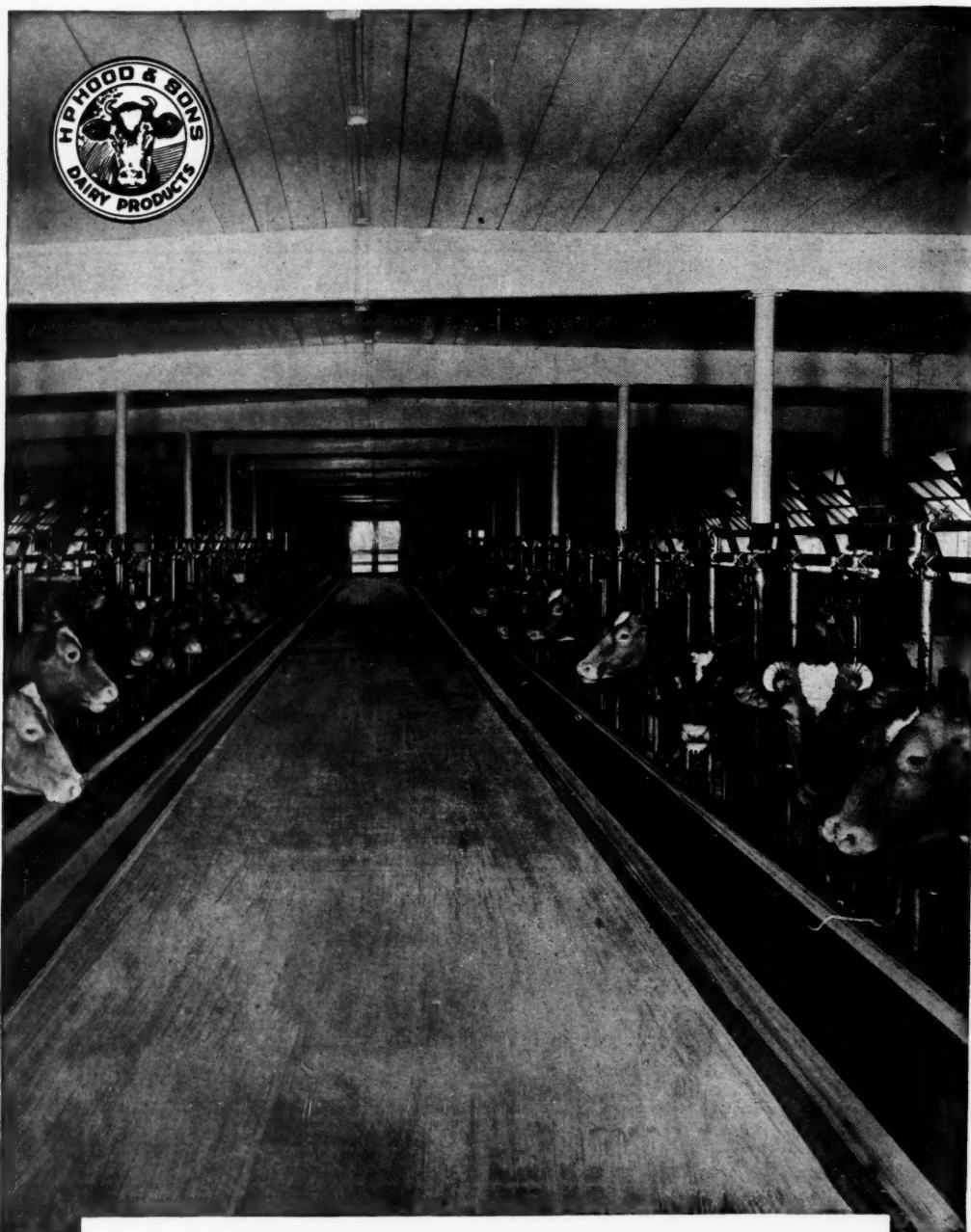
- DR. FRANK M. ADAMS — *Head Colds*. Alone, 20 min.
- DR. J. A. ALSTON — *Shock Therapies in Mental Disease*. Alone or with Dr. Ruggles or Dr. Alexander, 50 to 60 min.
- DR. C. J. ASHWORTH — *Peptic Ulcer (1), Gastric Carcinoma (2), Cancer of Colon (3), Appendicitis (4), Radium Therapy (5)*. Alone.
- DR. R. C. BATES — *Pediatrics; Allergy*. With Dr. Buffum or Dr. Utter, 20-25 min.
- DR. VERA M. BEHRENDT — *Psychiatry; Mental Hygiene*. Alone, time as arranged.
- DR. E. W. BENJAMIN — *X-ray Diagnosis; X-ray Treatment*. Alone, 10 to 60 min.
- DR. TEMPLE BURLING — *Parent Child Relationships; Behavior Problems*. Alone, 3 to 45 min.
- DR. W. B. COHEN — *Diagnosis and Treatment of Common Skin Diseases; Penicillin Treatment of Syphilis*. Alone or with Dr. Sawyer or Dr. Ronchese, 30 min., slides.
- DR. FRANCIS CORRIGAN — *Immunization; Rheumatic Fever; Pediatrics*. Alone.
- DR. J. N. CORSELLO — *Chronic Diseases of the Chest*. Alone, 30 min.
- DR. ANTHONY CORVESE — *What Can the Medical Profession do to Prevent Socialized Medicine (1), Carcinoma of the Rectum (2)*. Alone, 20 min.
- DR. FRANK A. CUMMINGS — *Gastro-intestinal Subjects (1), Obesity-Malnutrition (2), Diet (3)*. Alone.
- DR. J. P. DEERY — *Industrial Health and Hygiene and Related Subjects*. Alone or with Dr. C. L. Farrell, 45 min., slides and movies.
- DR. F. W. DIMMITT — *Vertigo (1), Retrobulbar Neuritis (2), The Ocular Fundi in Arterio-sclerosis (3), Glaucoma, A Common Eye Disorder (4)*. Alone, 25 min.
- DR. W. P. D'UGO — *Hypertension, Arthritis, Diabetes Mellitus*. Alone.
- DR. J. P. EDDY — *Experiences with Sympathectomy*. Alone, 40 min.; *Varicose Veins*. Alone, 15 min.
- DR. C. L. FARRELL — *Socialized Medicine; The Cults; Medical Economics and Legislation*. Alone, 45 to 60 min.
- DR. J. W. FISHBEN — *The Common Cold - Sinus Infections*. Alone, 30 min. or less. Slides and movies.
- DR. E. A. FIELD — *Roentgenology - Gastro-enterology*. Alone, 15 to 45 min., slides.
- DR. A. H. FOX — *Gout - A-dynamic Ileus*. Alone, 30 min.
- DR. ARCADIE GUIRA — *Limitations of General Practice*. Alone, 20 min.
- DR. R. T. HENRY — *The Use of Traction in Fractures, Steps in the Nailing of Fractured Hips*. Alone 30-45 min., slides.
- DR. R. R. HUNT — *X-rays in Obstetrics*. Alone, 40 to 45 min., films.
- DR. HARRY KECHJIAN — *Varicose Ulcers*. Alone, 15 min.
- DR. E. F. KELLY — *Pediatrics, Rheumatic Heart Disease in Children*. Alone or with Dr. Corrigan or Dr. Bates, 30 to 40 min.
- DR. J. F. KENNEY — *Any Medical Subject*.
- DR. T. A. KROLICKI — *Sigmoidoscopy, Ano-rectal Surgery*. Alone.
- DR. JOHN LANGDON — *Pediatrics - Feeding and Growth (1), Preventive Medicine (2)*. Alone, 30 min.
- DR. C. B. LEECH — *Cardio-vascular and Heart Disease*. Alone.
- DR. S. G. LENZNER — *Cancer*. Alone, 10 to 15 min.
- DR. J. P. MCCAFFREY — *Ectopic Pregnancy, Peritoneal Tuberculosis, Ovarian Cancer*. Alone, 30 min., slides.
- DR. J. F. MURPHY — *Obstetrics and Gynecology*. Alone, slides.
- DR. H. C. PITTS — *Cancer*. Alone, 20 to 30 min.
- DR. J. F. REGAN — *State Hospital for Mental Diseases (1), Psychiatry (2)*. Alone, 30 min., slides.
- DR. FLORENCE M. ROSS — *The Body, Its Physiology and Hygiene (1), First Aid for Hemorrhage (2), Immunization Against Children's Diseases*. Movies, slides and apparatus.
- DR. AMY E. RUSSELL — *General or Institutional Medicine*. Alone, about 30 min.
- DR. MEYER SAKLAD — *Anaesthesia (1), Inhalation Therapy (2), Resuscitation (3), Diagnostic and Therapeutic Nerve Block (4)*.
- DR. PERRY SPERBER — *Allergy*. Alone, 30 min.

continued on page 689

PHYSICIAN'S ASSISTANT

Young woman wishes position as receptionist, typist, laboratory assistant. Biology degree; theoretical knowledge of diagnosis and therapy gained writing and editing medical and technical reports and books. Also desires full time or free lance writing or manuscript editing, typing, and proofreading; familiar with A.M.A. manuscript requirements. References.

BOX 19. RHODE ISLAND MEDICAL JOURNAL



In order to become a Hood producer, a dairy farmer must first prove that he can meet and maintain the high standards of farm operation H. P. Hood & Sons have established to safeguard the purity and quality of Hood's Milk.

H. P. HOOD & SONS

FACULTY ROSTER

concluded from page 687

- DR. J. G. WALSH — *Obstetrical Topics*. Alone, about 30 min.
- DR. HENRY WEYLER — *Heart Sounds* (1), *Virus Infection* (2). Alone, 45 min, slides.
- DR. ESKE WINDSBERG — *Transverse Incisions in Abdominal Surgery* (1), *The McBurney Incision in Acute Appendicitis* (2). Alone, 30 min.
- DR. MALCOLM WINKLER — *Fungus Diseases of the Skin, Cancer of the Skin*. Alone, 30 to 50 min.

METROPOLITAN PLANS CANCER EDUCATION CAMPAIGN

The mortality from cancer, particularly among women, is beginning to come under control. This is indicated by the experience among the many millions of Industrial policyholders of the Metropolitan Life Insurance Company and is confirmed by other sources. In the past decade, for example, the age-adjusted death rate from cancer among insured white females dropped 11 percent at ages 1 to 74 years; virtually every important age group shared in the improvement. The current mortality from the disease among women in the broad age range 35 to 64 is the lowest in a third of a century, having dropped by one fifth during that period.

Among white male policyholders, too, a favorable indication is noted. The distinctly upward trend which had been manifested for many years has been stemmed. In fact, during the past decade, at no age beyond 25 years has the cancer death rate among these men shown any increase, and at some age periods the mortality has tended downward recently.

That the organized movement to control cancer is bearing fruit is evident from the fact that people, and more especially women, are seeking diagnosis and treatment earlier in the course of the disease, when the chances of cure are best. For example, among the patients at the cancer clinics in Massachusetts, the average delay between first symptoms and visit to physician was reduced from somewhat more than six months in the period 1927 to 1935, to 3.3 months in 1943.

To give further impetus to this movement, the Metropolitan Life Insurance Company is conducting a special campaign during October. At that time, the Company's more than 20,000 Field Representatives, in cooperation in many communities with official and voluntary agencies, will distribute to practicing physicians a special packet of new information on cancer. Included will be the American Cancer Society's booklet, "The General Practitioner and the Cancer Patient"; a reprint of recent studies of cancer mortality prepared by the statisticians of the Metropolitan; a reproduction of the Company's educational advertisement on cancer, "Cancer Has Its Hopeful Side!," appearing during October in national magazines with a combined circulation of about 30,000,000 readers; and a copy of the Company's new leaflet for laymen, "There Is Something You Can Do About Cancer." As part of this "message of hope about cancer," Metropolitan Field Representatives will endeavor to place the latter publication in more than one million homes. In addition, these representatives will place in prominent locations in their communities 6,000 window cards urging early diagnosis of cancer.

Guards the PORT of ENTRY

We think many colds could
be avoided by the daily
use of ALKALOL
as a nasal douche.

ALKALOL dissolves mucus,
cleans and soothes the
nasal membranes.

It's a good routine to suggest
to your patients.

The ALKALOL Company
TAUNTON, MASSACHUSETTS

OXYGEN

**CARBON DIOXID-OXYGEN
MIXTURES**

HELIUM-OXYGEN MIXTURES

NITROUS OXID

CARBON DIOXID

CYCLOPROPANE

* * *

OXYGEN TENTS, FACE MASKS

For Sale or For Rent

CORP BROTHERS

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24 Hour Service

Announcing...

**A THERAPEUTIC FORMULA
FOR VITAMIN DEFICIENCIES**

HYPERVITAM

A THERAPEUTIC VITAMIN FORMULA

Daily dose of 3 CAPSULES contains:

Vitamin A	30,000 U.S.P. Units
Thiamine (B ₁)	30 mg.
Riboflavin (B ₂)	15 mg.
Niacinamide	150 mg.
Pyridoxine (B ₆)	3 mg.
Calcium Pantothenate	15 mg.
Ascorbic Acid (C)	300 mg.
Vitamin D	3,000 U.S.P. Units
Alpha Tocopherol (E)	30 mg.

HYPERVITAM* embodies 2 basic principles
in the therapy of vitamin deficiencies:

1. MORE COMPLETE FORMULA—vitamin deficiency symptoms are almost always multiple, rarely single.
2. EXCEPTIONALLY HIGH POTENCIES—vitamin deficiency diseases should be treated with intensive dosage . . . in divided doses for maintaining more uniform blood levels.

U. S. VITAMIN CORPORATION
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1936—with multiple vitamin-mineral diet supplement—VI-SYNERAL

1943—with aqueous preparation combining fat- and water-soluble vitamins—VI-SYNERAL VITAMIN DROPS

1940—with injectable preparation of Vitamin B₁ complex factors—POLY-B SPECIAL

1945—with therapeutic vitamin formula—HYPERVITAM

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